Medical Economics

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Also in this issue...

How the Keogh Bill Could Change Your Life

The Facts About Lloyd's Malpractice Insurance

Medical Economics

NEWS BRIEFS

M.D.s STILL CAN'T TEACH BIRTH CONTROL in Connecticut. A bill to end the state's ban on contraceptives has died in the Legislature. Meanwhile, a suit by Yale's Dr. Charles Buxton to get the law repealed awaits trial by the State Supreme Court.

WHAT'S THE MEDIAN FEE NOW for a polio shot? A recent survey by this magazine shows it's $4 among G.P.s, $6 among specialists.

PROFESSIONAL COURTESY HAS LOST MORE GROUND to Blue Shield in New Jersey. Doctors in 4 of the state's 21 county medical societies now have group coverage to pay for their own medical care. And members of a fifth county society—the state's largest—recently voted to enroll.

NEW SOCIAL SECURITY POLL RESULTS have come in from several states in recent weeks. Michigan and New Jersey doctors want it; those in Arkansas, Maryland, Oklahoma, and Texas don't.

NEWS BRIEFS

FOREIGN-STOCK INVESTMENT WARNING: "Risks of political upheaval, expropriation, [and] exchange restriction...continue to haunt the foreign market," says the American Stock Exchange. "Only the well informed should send his money abroad."

UNEXPECTED DROP IN MEDICAL SCHOOL APPLICANTS for last year's freshman class has been reported by the Association of American Medical Colleges. The A.A.M.C. estimated earlier that 16,800 students had applied. Now, however, it finds only 15,791 did. That's 126 fewer than in the previous year.

DOCTORS HAVE A $35,000,000 STAKE in the current steel-industry talks: That's what the steelworkers pay into the Blue plans yearly. But United Steelworkers President David McDonald has threatened to drop the Blues and set up his own health plan. To do this, he'd need a major fringe benefit hike from industry. If he gets one now, he'll be that much closer to carrying out his threat.

"OUR NATION'S ECONOMIC SITUATION TODAY is dangerously vulnerable," says a recent bleak warning from the American Institute for Economic Research. "Our guess today," it adds, "is that another devaluation of the dollar will be undertaken" within the next few years. "We do not believe that necessarily...will prevent a severe depression."

HOW SICK IS BLUE CROSS? Pain in its treasuries is acute. Last year the plans took $40,000,000 out of reserves—five times more than in 1957.

A NURSE BROUGHT THE WRONG BLOOD to Yonkers (N.Y.) Surgeon Stanford Pulrang during an operation. But neither Dr. Pulrang nor the lay anesthetist who gave the transfusion stopped to check. The patient died. Now a jury has assessed damages of $150,000 against the hospital, Dr. Pulrang, and Anesthesiologist-in-Charge Harry Rubin. It's the first time M.D.s have been held liable in a "wrong-blood" transfusion. The case has been appealed.

IF YOU "DROP A NICKEL ON THE DRUM" for the Salvation Army, it's now considered a church donation and is deductible under the 30%-of-income limit, says a new Internal Revenue Service ruling.

UNION TROUBLE MOUNTED for New York City medical men when nontechnical workers at 6 voluntary hospitals recently struck for union recognition and wage hikes. Hospital men say they can't raise wages unless they get bigger payments from Blue Cross. So 4 unionists on New York Blue Cross' board of directors want the plan to raise its payments to hospitals. But these same unionists are fighting a recent Blue Cross proposal to raise subscribers' premiums by 34%.

NEWS BRIEFS

SERVICE HEALTH CONTRACTS NOT WANTED: Texas doctors have amended their state society's bylaws to prevent it from officially adopting any fee schedule (such as that in a service-benefits health plan) that would dictate doctors' charges.

CLOSED-PANEL MEDICINE VS. FREE CHOICE: Of 11 state medical societies that have met in recent weeks, 7 passed resolutions firmly endorsing the free-choice principle and opposing closed-panel plans. Three others took no action on these issues, and 1 passed a noncommittal resolution.

M.D.s AND Rx-MEN ARE FURIOUS over a new law in Nevada. It bars druggists from paying rebates to doctors who refer customers to them. "Such rebating is negligible here," says Nelson Neff, state society secretary. "There's just no need for the bill." Why was it passed? Says a prominent Reno druggist: "Because one powerful Senator who's anti-M.D. and anti-pharmacist pushed it through."

PATIENT-LOADS HAVE DWINDLED at 3 Scranton (Pa.) hospitals, chiefly because they're unaccredited. So the United Fund plans to cut its grants to these hospitals. "That'll close them down," hospital men warn. And Scranton's M.D.s are steaming. "Give the hospitals more money, not less," they urge, "so they can meet accreditation standards."

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Stuart

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Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, MAY 25, 1959

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[1]Price, A. H., et al.: J.A.M.A. 167:1612, 1958.

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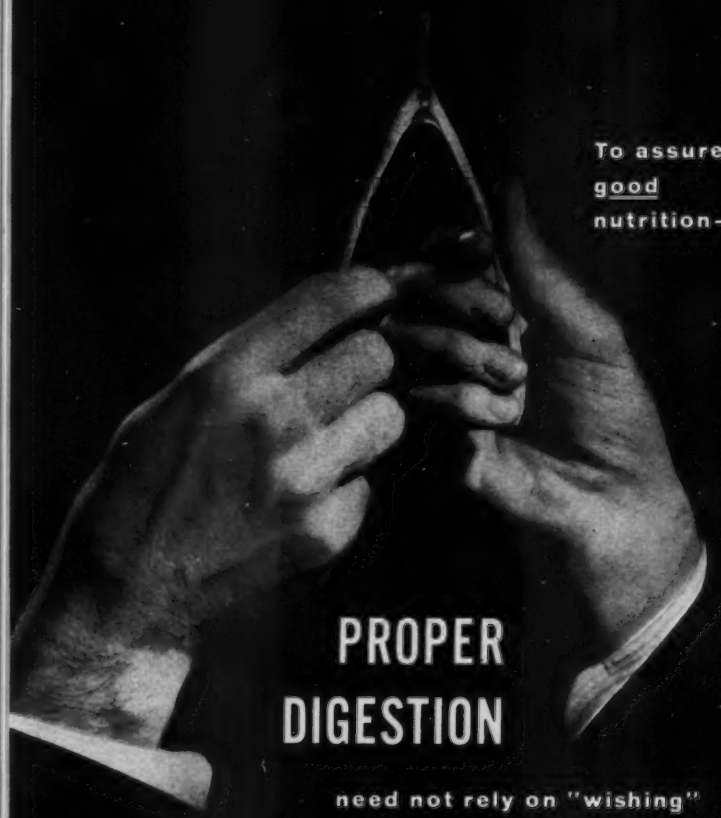

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Letters

'Spoiled Internes'

SIRS: In my day, the interne was distinctly the bottom man on the totem pole. He was run ragged with work, bawled out as a routine matter, and happy to get room, board, and laundry service.

Today the hospitals kowtow to these youngsters to a nauseating degree. The patient-load is sharply limited, so as not to overwork the poor boys. They're given salaries of $250 a month or better, plus free educational programs. Five internes do the work that one or two internes used to find not too burdensome.

With the astronomical rise in hospital costs, isn't this situation ripe for review?

M.D., Massachusetts

Rockefeller's Compulsion

SIRS: So Governor Nelson Rockefeller proposes that New York employers be compelled to provide major medical insurance for their employes! Any such action would bring medicine closer to governmental supervision. How much closer depends on the eventual answers to these two questions:

Would the *only* element of compulsion be that the employer provide the coverage? And to what extent would the state prescribe *standards* of coverage?

In any case, medicine should do all in its power to make sure that government control wouldn't encroach on any vital area of professional responsibility.

James E. Bryan
Health Insurance Consultant
Stamford, Conn.

SIRS: ...Compulsory health insurance in a pink pill is still bad.

Howard Hassard, LL.B.
Legal Counsel
California Medical Association
San Francisco, Calif.

Diagnostic Centers Needed?

SIRS: You report that Dr. Norton S. Brown, president of the New York County medical society, believes that centralized diagnostic facilities should be available for all doctors. His idea is to cut down on unnecessary hospitalization for diagnostic tests.

But surely Dr. Brown must know that the diagnostic services to which he refers are already widely available at the offices of pathologists and/or radiologists. There the patient not only gets bet-

Letters

ter and more personal service, but he's often charged less than he would be at the out-patient department of a hospital.

Martin B. Goodwin, M.D.
Clovis, N.M.

SIRS: . . . Dr. Brown suggests such centers be placed in hospitals. If so, the hospitals will insist on controlling them. Trustees and administrators aren't apt to let a hospital facility be directed by privately practicing physicians. On the other hand, when such centers have been established outside the hospital, they've often led to fee splitting, exploitation of patients, and unnecessary referrals.

Dr. Brown ignores the well-equipped offices of thousands of radiologists in private practice.

Earl E. Barth, M.D.
Chairman, Board of Chancellors
The American College of Radiology
Chicago, Ill.

The Seductive Patient

SIRS: The author of "How to Deal With the Seductive Patient" suggests warding her off by advising her to see a psychiatrist. I've had no personal experience with amorous patients. But I don't think this advice is sound.

If the woman is rejected with the insulting implication that she's not only nuts about the doctor but nuts, period, she may pull the Potiphar's wife routine and charge the doctor with making improper advances, or even attempted rape. Hell hath no fury, etc.

I think a cowardly way out would be better. Tell her you'll call her up tomorrow and make a date for a better time, because your nurse is expected back any moment. Or tell her you have an appointment at the hospital in ten minutes. Or that your wife is picking you up in five minutes. Or that you respect and admire her too much to take advantage of a moment of weakness.

Best of all, never let yourself be entirely alone with a female patient!

Lyon Steine, M.D.
Valley Stream, N. Y.

Only Human

SIRS: Please let's have some more frank articles on aides' salaries. Doctors don't seem to realize we want to live, not just exist . . .

Doctor's Aide, California

SIRS: . . . The doctors all forget we're human too, with bills and obligations—and a human need for incentive and encouragement . . . Many a person who has trained for medical work later regrets it because of the low salaries. *More*▶

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Letters

No wonder some doctors have to get a new aide four times a year.

Doctor's Aide, Maryland

SIRS: . . . He makes close to $75,000 a year, yet couldn't afford to give me a raise for three years . . . Don't get me wrong. There are many good things about working as a doctor's aide—otherwise I wouldn't have spent my life in the field. BUT . . . you're expected to be a receptionist, bookkeeper, X-ray technician, secretary, nurse, and, quite often, a personal maid for his family—all for $200 to $300 a month. Forty-hour week? Overtime pay? Who ever heard of them in a doctor's office!

Medical Secretary, Tennessee

Credit Card Practice

SIRS: I wonder how one of the new Diners Club type of credit cards would work as a means of paying doctor bills. Would there be drawbacks to it?

Werner Bergmann, M.D.
Oakland, Calif.

The idea is being discussed in some areas. One organization already offers to pay 60 per cent of the patient's bill at once; give the doctor an eighteen-month promissory note for 30 per cent; and retain 10 per cent for handling and profit. But the Chicago Medical Society recently refused to advertise this plan in its bulletin. And the Toledo and Lucas County (Ohio) Academy of Medicine has officially disapproved the plan. Comments the Ohio doctors' journal: "Very few doctors [routinely need] to pay a 10 per cent fee for collection of bills. [This plan] would pave the way for an undesirable increase in the doctor's fees."—ED.

Overdone Nest Eggs

SIRS: How many M.D.s, like the physicians described by Management Consultant Nelson J. Young in "The Nest Egg You Need," have gross incomes of $75,000 and up? How many actually have $500,000 to leave to a daughter?

Such misleading articles do a disservice to the medical profession.

In my opinion, the average M.D. is much overworked and frightfully underpaid.

Louis Keating, M.D.
Yonkers, N.Y.

The article's case histories had to do with doctors so intent on building up unnecessarily large retirement funds that they never stopped to enjoy life. Our sincere regrets if these "horrible examples" weren't taken as such.—ED. END

"It is concluded that the addition of buffering agents to acetylsalicylic acid in the concentrations used serves no clinically detectable useful purpose."[1]

[1]Sadove, Max S. and Schwartz, Lester: An Evaluation of Buffered Versus Nonbuffered Acetylsalicylic Acid, Postgraduate Medicine; 24:163, August, 1958.
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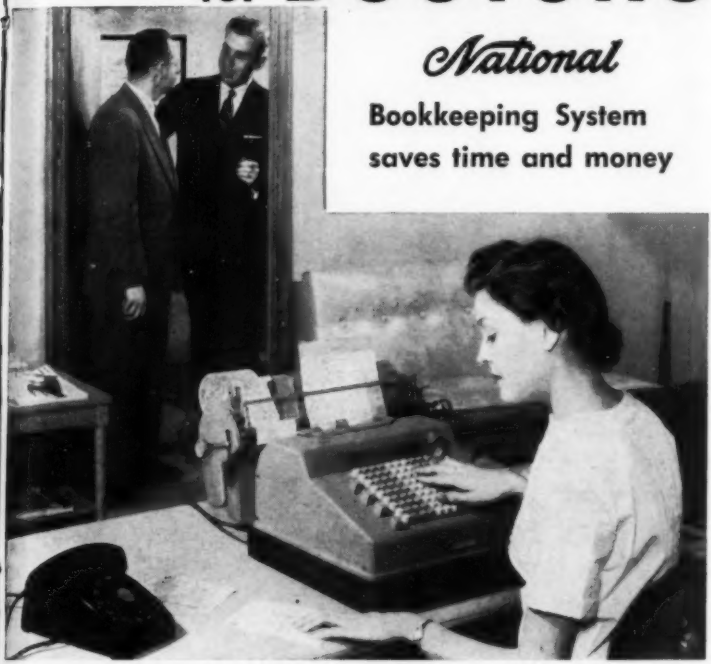

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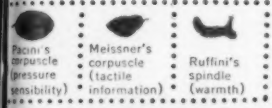

1. Weiner, H. H.: Clin. Med. 5:25 (Jan.) 1958.
2. Giorlando, S. W., and Brandt, M. L.: Am. J. Obst. & Gynec. 76:666 (Sept.) 1958.

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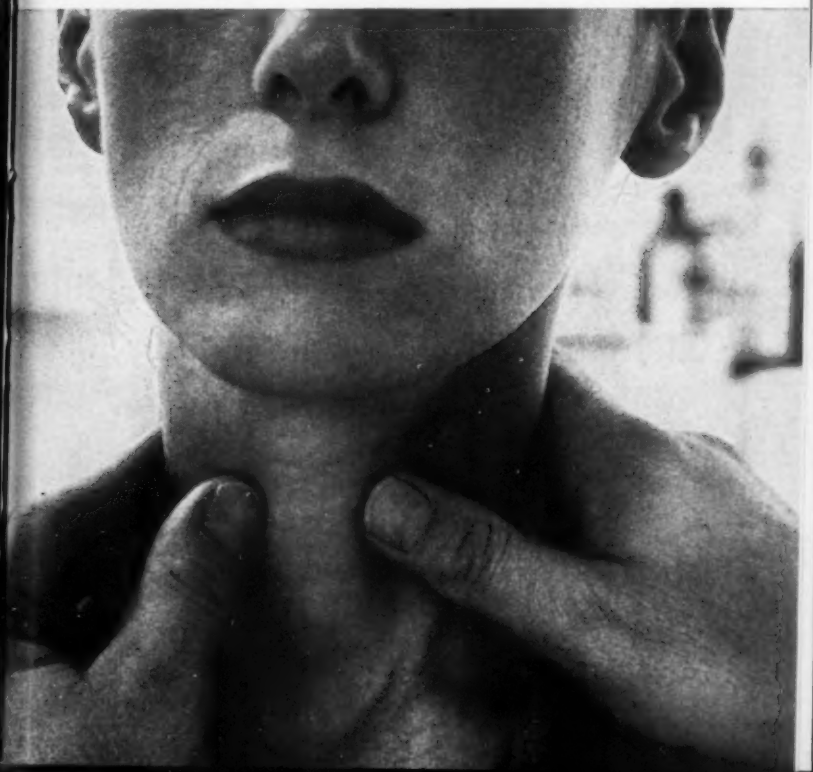

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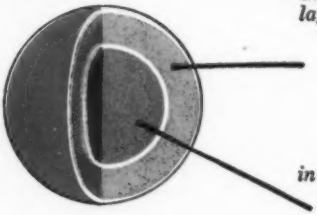

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1. Nulsen, R. O.: Ohio State M. J. 53:665, 1957. 2. Personal communications, 1956-57.

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News • News • New

Wall Street Warns: 'Don't Overrate Electronics'

What's the glamour industry of the current stock market? Many investors would say electronics. But the public's enthusiasm for electronics stocks worries some Wall Streeters. A recent statement by the American Stock Exchange gives this nonglamorous picture of industry prospects:

"More and more things are being done by electronics. This includes making or losing money in the stock market."

Sure, the electronics field offers tremendous growth possibilities, the Exchange continues—but not every electronics firm is going to grow. As the Exchange sees it:

'Electronics today is . . . comparable to . . . the radio industry in the '20s when hundreds of companies began their struggle to be the giants of today. Just a few made the grade. Many did not survive."

This view is seconded by Financial Editor Donald I. Rogers of the New York Herald Tribune. He points out that even picking the future leaders of the electronics industry doesn't assure an investor of profits:

"Investors who bought Radio Corporation of America at its 1929 high . . . have only lately begun to get their money back, despite the phenomenal progress the company has made over the years."

Concludes the financial editor: "When you're buying growth stocks, the price has to be right."

Drive to Unionize Hospitals May Spread Across U.S.

Patients will pay higher hospital charges and stiffer health insurance premiums—and voluntary hospitals will have a tougher time making ends meet—if a movement that's now afoot in our largest city spreads across the country.

Three union locals are trying to organize nontechnical workers in New York's eighty-one nonprofit hospitals. The unionists' ultimate goal: substantial wage hikes.

Most headway so far is claimed by Local 1199 of the Retail Drug Employes Union. It has already won recognition by the Maimonedes and Montefiore hospitals, and it claims to have signed up a majority of workers in twelve other voluntary institutions. It's getting a tough run for new members,

News·News

though, from Local 302 of the American Federation of State, County, and Municipal Employes, and from Local 237 of the International Brotherhood of Teamsters.

Already the unionists have caused New York hospital men plenty of headaches.

¶ Local 1199 won recognition at Montefiore Hospital only by threatening to strike. It did strike briefly at Mt. Sinai Hospital. And unionists in five other hospitals where Local 1199 claims majority membership have voted to strike unless it's recognized.

¶ Supply deliveries have been halted briefly at New York Hospital and at Presbyterian Hospital by pickets from both the Teamsters and the A.F.S.C.M.E. locals.

Furthermore, the unionizing drive threatens to spread coast to coast. A Florida Teamsters local has already begun signing up workers in Miami's county hospitals. And A.F.S.C.M.E. President Arnold Zander says his union's eventual goal is to enroll some 500,000 workers in hospitals nationwide.

As Henry Feinstein, New York Teamsters local president, put it recently: "This...is only a start... The hospitals seem to want war. Well, they'll get one. [We'll] have a lot of fun before this is over."

How much Feinstein's and his fellow-unionists' campaign may

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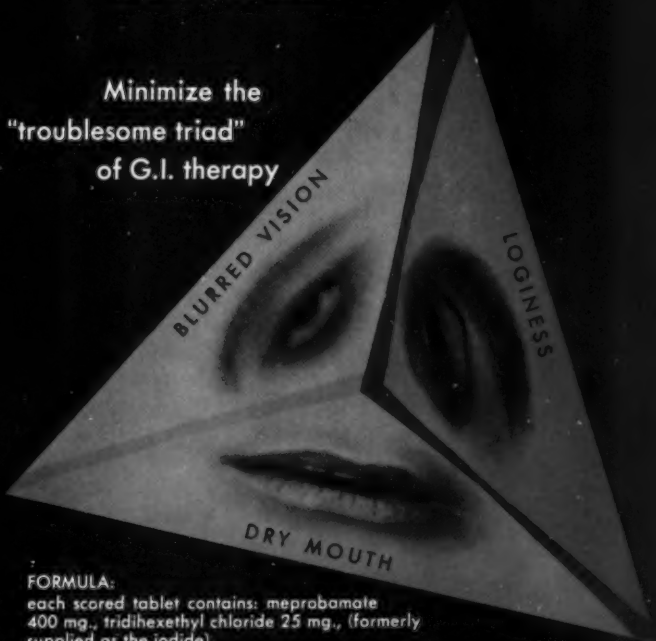

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1. Bandes, J.: Combined Drug Therapy in Gastrointestinal Disturbances; Increased benefit through diminished side reactions, Am. J. Gastroenterol. 30:600, Dec. 1958.

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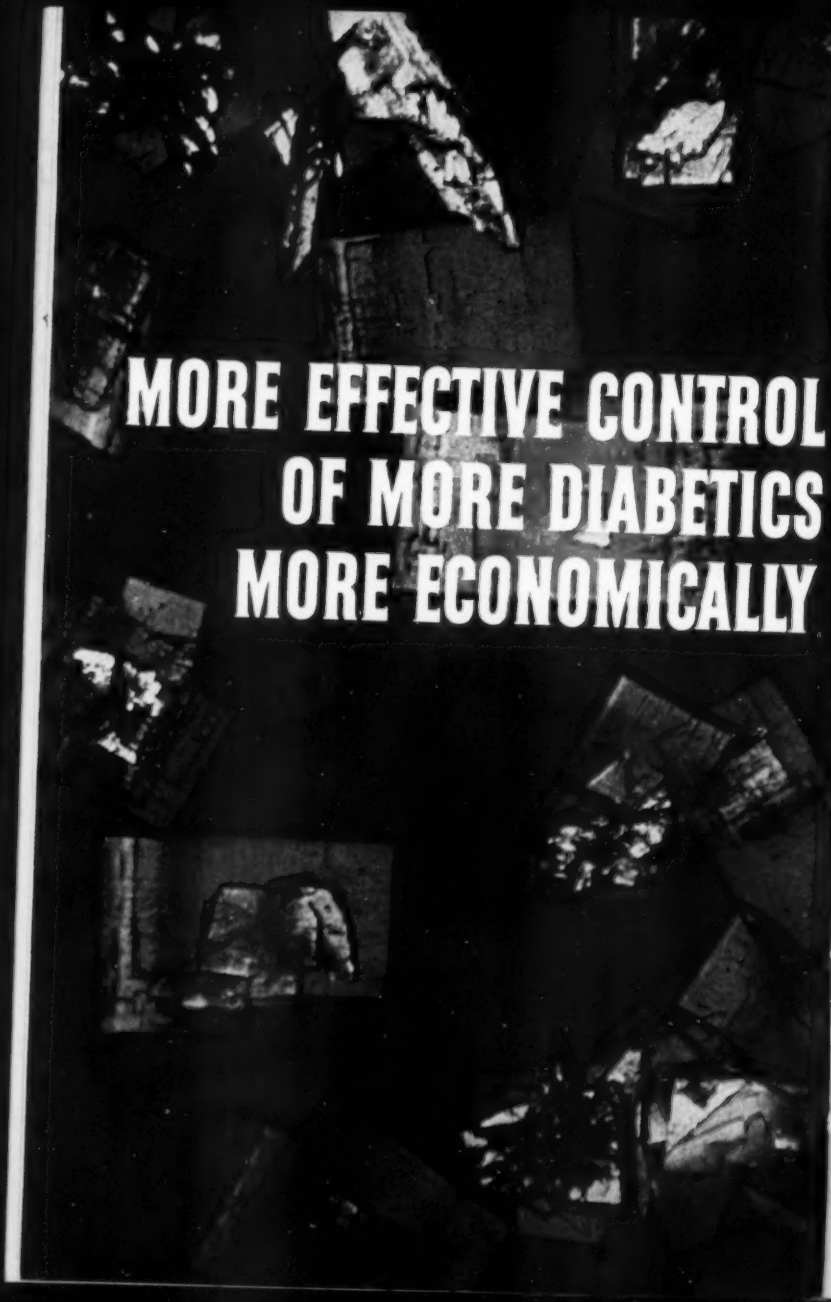
MORE EFFECTIVE CONTROL
OF MORE DIABETICS
MORE ECONOMICALLY

cost patients and hospitals can be gauged by reports from cities where nonprofit-hospital workers are already unionized. In Minneapolis and San Francisco, for example, the cost per patient-day in unionized hospitals is now estimated at $38 to $40. In New York, this figure ranges around $27 per day. And Blue Cross coverage that now costs $10 per month in Minneapolis costs only $5.34 in New York.

State Gives Pensioners Six Doctor Visits a Year

Now doctors in one more state will get paid for treating indigent old-age patients outside a hospital. The Colorado Welfare Board last month proposed that the state's pensioner health program cover office visits (at $3) and house calls (at $5). The pensioners—who must be indigent and past 65—are limited to two visits every three months, with a maximum of six visits to or by a doctor a year.

Why the limited number of visits? State Welfare Director Guy R. Justis justifies it as a start, at least, by citing what's happening in those states which have more liberal allowances.

In Rhode Island, he notes, pensioners are allowed ninety-six paid visits a year; yet they've been averaging less than five. Connecticut allows eighty-four visits; its pensioners use an average of five. And in Maryland, where there's no limit, pensioners average seven annual visits, according to Justis.

Payments for out-of-hospital care will be administered by Colorado Blue Shield-Blue Cross. The Blue plans also handle the hospitalization and surgical coverage that the old-age pensioners have been getting from the state.

The six-visits-a-year plan won out over a more controversial proposal. The discarded plan was to issue $24 worth of doctor-payment coupons a year to each of the 54,000 pensioners. Then the pensioner and the physician would have been free to negotiate fees. But a public outcry about possible abuses—even Colorado's Governor chimed in—forced the welfare board to drop the coupon idea.

A.M.A. Titleholder Couldn't Find a Successor

Which young doctor will some day take over the practice of the nation's star G.P.? Apparently none, according to L. A. Coffin, whom the A.M.A. chose as General Practitioner of the Year for 1959.

Before he died last month, he was seeking a doctor "with a sense of mission" to work into his busy Farmington, Iowa, practice. But

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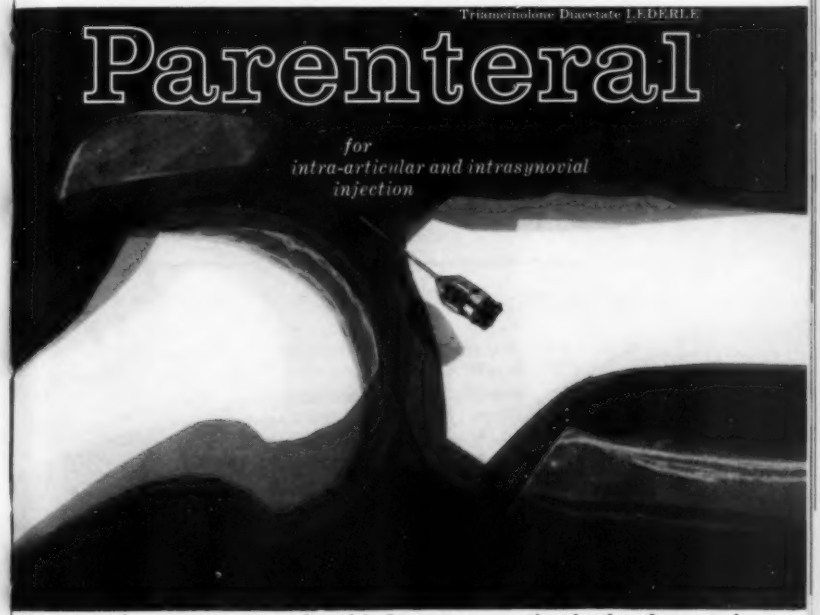
Parenteral

for
intra-articular and intrasynovial
injection



longer and *more pronounced* anti-inflammatory action in the *shortest time*

when systemic therapy is contraindicated • when systemic corticosteroids produce serious side effects • to secure quick relief in one or two joints • for use in conjunction with orthopedic procedures

Indications: rheumatoid arthritis; osteoarthritis; bursitis; peritendinitis; ganglion; intermittent hydroarthrosis; epicondylitis and related conditions.

ARISTOCORT Parenteral contains: 25 mg. per cc. of ARISTOCORT® Triamcinolone Diacetate micronized; polysorbate 80 U.S.P. 0.10%; benzyl alcohol 0.95%; benzalkonium chloride 0.01%; sorbitol solution N.F. 84.83%, and water for injection q.s. 100%.

All precautions required for intra-articular and intrasynovial administration of other corticosteroids should also be observed with ARISTOCORT Parenteral.

Complete information on dosage and administration is included in the package circular.

Supply: Vials of 5 cc. (25 mg. per cc.)

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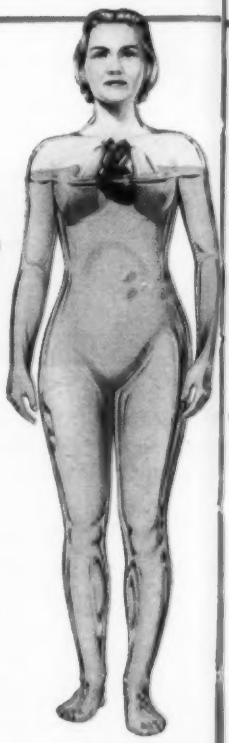
IN EDEMA:

- shows greater oral effectiveness than any other class of diuretic agent
- each 25 mg. HYDRODIURIL orally is equivalent to 1.6 cc. meralluride I.M.
- has been reported to be effective even in patients who do not respond satisfactorily to other diuretics
- has prompt onset of action with diuretic effectiveness maintained even on prolonged daily administration
- low toxicity—extremely well tolerated
- often achieves the benefits of a low salt diet without the unpleasant restriction



Indications: Hypertension, congestive heart failure of all degrees of severity, premenstrual syndrome (edema), edema and toxemia of pregnancy, renal edema—nephrosis, nephritis; cirrhosis with ascites, drug-induced edema, and as adjunctive therapy in the management of obesity complicated by edema.

dosage: In edema—one or two 50 mg. tablets of HYDRODIURIL once or twice a day.

In hypertension—one or two 25 mg. tablets or one 50 mg. tablet HYDRODIURIL once or twice a day.

supplied: 25 mg. and 50 mg. scored tablets HYDRODIURIL (Hydrochlorothiazide) in bottles of 100 and 1,000.

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Additional information on HYDRODIURIL is available to the physician on request.

bibliography: 1. Esch, A. F., Wilson, I. M. and Freis, E. D.: 3,4-Dihydrochlorothiazide: Clinical Evaluation of a New Saluretic Agent. Preliminary Report; M. Ann. District of Columbia **28**:9, (Jan.) 1959. 2. Ford, R. V.: The Clinical Pharmacology of Hydrochlorothiazide; Southern Med. J. **52**:40, (Jan.) 1959. 3. Fuchs, M., Bodi, T., Irie, S. and Moyer, J. H.: Preliminary Evaluation of Hydrochlorothiazide ('HYDRODIURIL'); M. Rec. & Ann. **51**:872, (Dec.) 1958. 4. Moyer, J. H., Fuchs, M., Irie, S. and Bodi, T.: Some Observations on the Pharmacology of Hydrochlorothiazide; Am. J. Cardiol. **3**:113, (Jan.) 1959.

HYDRODIURIL (HYDROCHLOROTHIAZIDE)

- highly-active derivative of chlorothiazide
- qualitatively similar to DIURIL® but at least 10 to 12 times more potent by weight
- loss of potassium is clinically insignificant in the great majority of patients on normal diets

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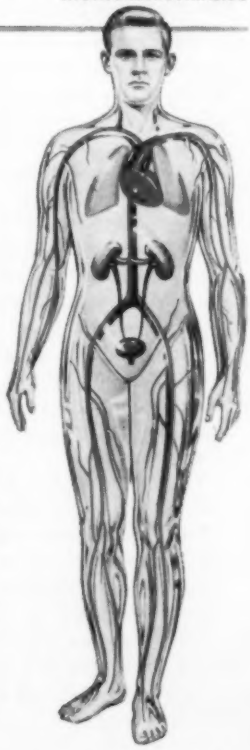

Precautions: It is important that the dosage be adjusted as frequently as the needs of the individual patient demand. When HYDRODIURIL is used with a ganglion blocking agent, it is mandatory to reduce the dose of the latter by at least 50 per cent, immediately upon adding HYDRODIURIL to the regimen.

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every young man he had asked, he said, had "grinned sheepishly and turned me down."

What's the trouble? "The medical profession has become too highly specialized," concluded Dr. Coffin.

Doctors Put a Legal Lock On Hospital Records

Medical men are increasingly worried about plaintiffs' attorneys who go prying in hospital files. Now doctors in one state have scored a major victory on that front. They've persuaded their law-makers to post "off limits" signs on hospital committee records.

In South Dakota a new law declares that information gathered by medical bodies "for the purpose of reducing morbidity or mortality" may not be used as evidence in court. And anyone who uses such information for any purpose other than medical research is guilty of a misdemeanor.

Credit for suggesting this law goes to the South Dakota Society of Obstetrics and Gynecology. But the OB/Gyn. men got even more than they asked for. Here's how the victory developed:

OB/Gyn. men believed doctors' fears about providing malpractice fodder were crippling their society's annual studies of childbirth mortality. So they suggested a remedy: a law patterned after one in Minnesota that makes state health department medical surveys immune from use in legal actions.

But the OB/Gyn. men wanted *their* law to protect surveys made by the South Dakota Medical Association "and allied societies" too. The state medical association put the idea into its legislative program. And the state legislators seemed receptive.

So then Dr. H. Russell Brown, legislative chairman for the state association, and Dr. A. A. Lampert, state president, went a step further. They threw in a clause covering surveys made by "in-hospital staff committees of accredited hospitals." In that form, the bill was passed.

Now South Dakota doctors can breathe easier when giving medical details to tissue committees.

How Some Investors Beat The Margin Rules

Nearly all doctor-investors pay cash when they buy securities—but not everyone does. The ways people are playing the market on credit came to light recently when the Federal Reserve Board proposed tightening the margin rules.

What disturbs the board is the number of speculators who've been beating the current 90 per cent

margin requirement. This supposedly requires securities buyers to pay their brokers at least 90 per cent cash. Here are two ways many speculators have been getting around the rule:

1. Speculators with older margin accounts have been allowed to keep the cash-stocks ratios they had in the more lenient days. For example:

Last year at this time, the legal margin was 50 per cent. Then a speculator with $1,000 in cash could have bought $2,000 worth of securities. (He borrowed the balance through his broker, paying about 5 per cent interest.) Since then, margin requirements have been raised, but that hasn't affected existing accounts. So the speculator who put up $1,000 cash a year ago has still been able to juggle his $2,000 portfolio.

2. Speculators have been stretching their cash by buying securities, then putting them up as collateral for a bank loan. With the borrowed cash, they've gone deeper into the market.

It's reported that banks have lent as much as 90 per cent of the value of certain securities. That's the equivalent of buying on a 10 per cent margin. Or, to put it another way, such a speculator ties up only $1,000 cash to hold $10,000 worth of securities.

Now the Federal Reserve Board wants to plug up these two loopholes. Most Wall Streeters expect new rules to affect stock prices.

Which way? The experts differ. But the prevailing opinion is that stiffer margin regulations will make speculators want to hang on to their present holdings.

This would tend to reduce the supply of securities offered for sale. Result: a general price rise.

Doctors Ask Ambulances to Stop for Red Lights

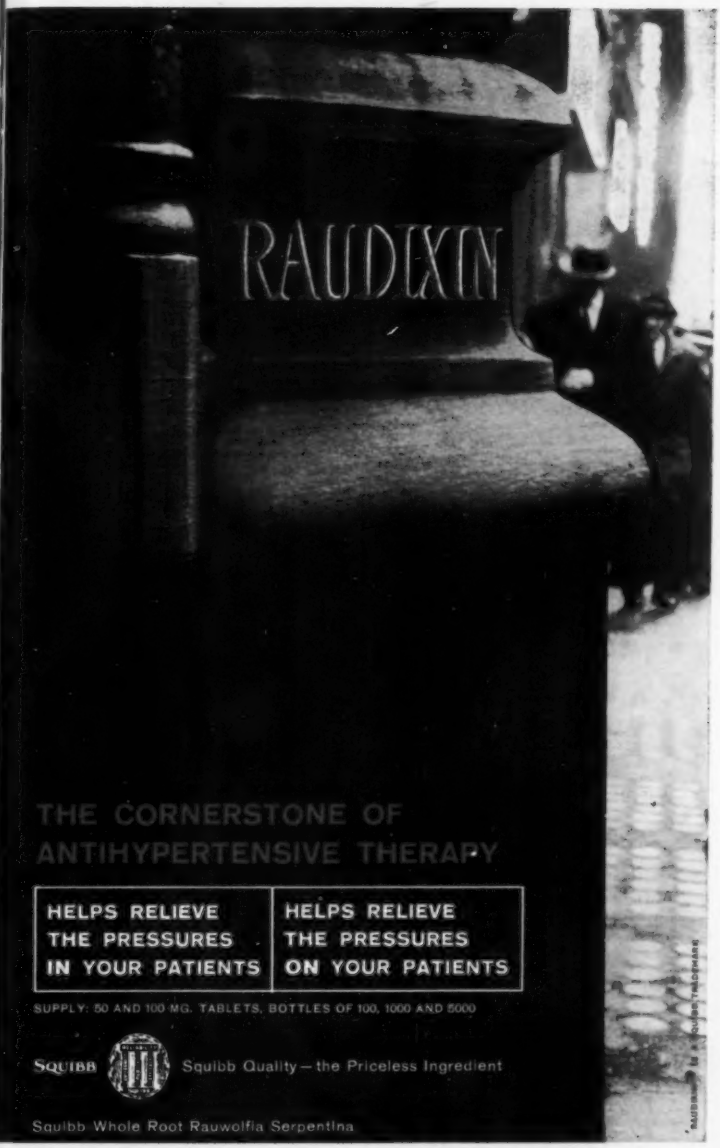
Should ambulance drivers be made to follow the same traffic regulations as everyone else? Yes, says the Charleston County (S.C.) Medical Society. Recently it told local governing bodies:

1. "Most [ambulance] accidents are caused by excessive speed or passing through red lights."

2. "It has been conclusively proved that rarely does a few minutes make a significant difference in the patient's outcome."

'Give a Patient Narcotics And He May Sue'

Doctors who treat drug addiction by prescribing narcotics risk more than prosecution by Treasury agents. They invite malpractice suits. So warns Federal Narcotics Commissioner H. J. Anslinger. *More*▶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In a letter to GP magazine, the commissioner tells of a doctor who ran afoul of the malpractice danger not long ago. Taken to court, the doctor was ordered to pay a "substantial sum" in damages. The patient's charge: The physician gave her "excessive quantities of morphine over a period of six years," thus turning her into an addict. "She alleged that she was forced into prostitution to pay the physician," Anslinger adds.

This incident, says the narcotics official, underlines what he dislikes about a recent report on the narcotics problem by the A.M.A. and the American Bar Association.

This report, as Anslinger sees it, (1) proposes that "addicts be furnished narcotics to maintain their addiction" and (2) argues that this policy would remove the need of addicts "to resort to crime and prostitution to pay the peddler." Anslinger himself is a stanch advocate of handling addicts as criminals.

More Firms Plan to Pay Dividends in Stock

Look for many more companies to declare dividends not in cash but in stock during the rest of this year. It's a sign of good times, market analysts say. Explains New York Broker Lloyd Haas: "When a firm pays dividends in stock, it can retain cash for financing growth and, at the same time, keep stockholders happy."

A main reason stockholders like getting dividends in stock is the tax advantage. Taxes aren't due on a stock dividend until the stockholder sells it. When he does, he pays a tax only on the stock's rise in value while he has held it. And if he has held the original stock longer than six months, he pays only a capital gains tax (maximum: 25 per cent) on the dividend.

Some investors question whether stock dividends pay off in the long run, since they don't actually increase the stockholder's ownership in the company.

But Haas says his studies show that the investor can gain anyway. He gains if his company is really putting its cash earnings into expansion and if it keeps the old dividend rate on the increased number of shares.

For these reasons investment counselors frequently suggest that investors in their prime earnings—and high tax—years buy into companies that are known to pay dividends in stock.

There are many such firms. To show what a wide range of industries they span, here's a small sampling of companies that have frequently declared stock dividends:

To meet her greater needs for diet supplementation

Natalins® Comprehensive
Vitamins and minerals, Mead Johnson

Natalins® Basic
Vitamins and minerals, Mead Johnson

both extra generous in iron, ascorbic acid and calcium

In a study[1] of over a thousand obstetrical patients, anemia was found to occur with 50% greater frequency in multiparas than in primigravidas. And it was found that anemia often indicates other nutritional deficiencies as well . . . Natalins Comprehensive tablets supply 12 vitamins and minerals and Natalins Basic tablets supply 4 vitamins and minerals . . . both are formulated to meet the special needs of multiparas by supplying generous amounts of elemental iron (40 mg. per tablet), ascorbic acid (100 mg. per tablet) and calcium (250 mg. per tablet).

Convenient, one-a-day tablet dosage.

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1. Traylor, J. B., and Turpin, R.: Am. J. Obst. & Gynec. 81: 71-76 (Jan.) 1961

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Blue Shield Drops Coverage; Other Plans Pick It Up

Can small nonprofit health insurance plans afford to cover groups that Blue Shield can't? Two New York plans are ready to try it. The Group Health Insurance plan and the closed-panel Health Insurance Plan of Greater New York say they'll offer coverage to many of the 100,000 subscribers whom Blue Shield has decided to drop.

Blue Shield has announced it's dropping its out-of-hospital coverage for groups of fewer than twenty-six employes. Continuing this coverage through 1959 would mean a loss of $2,200,000, says Dr. Louis H. Bauer, board chairman of New York City's Blue Shield plan.

But G.H.I.'s president, Arthur H. Harlow Jr., thinks his plan can "break even" by offering such coverage to groups of ten or more. G.H.I. is a nonprofit comprehensive plan with a quarter-million

subscribers. It already offers house-call and office coverage to large employe groups under its Family Doctor Plan.

Of the small-company field, Harlow says: "This is a high claim group. But people need [out-of-hospital coverage] and that's why we're in business."

H.I.P. also offers prepaid house-call and office care to the 10-25 employe groups formerly covered by Blue Shield.

The premium? The same as for large-group coverage, both plans say.

Security in State Medicine? These Doctors Say No

Ever wonder what practice is like for doctors behind the Iron Curtain? Ophthalmologist Conrad A. Mietus of Buffalo recently spent a month there as the U.S. State Department-approved guest of the Polish Society of Ophthalmologists. Here's what he found in Poland:

"There is very little private practice," for several reasons, Dr. Mietus says. "Office space is lacking, as even living quarters are at a premium . . . and further because all living space is controlled by the city. There are no surgical supply houses to outfit a private office, as all industries are owned by the government . . . Instruments cannot be purchased outside the country . . . as not one dollar can be sent out."

Where *do* doctors practice? In state-run hospitals or clinics, Dr. Mietus reports. "The first rule that governs both medical and dental practice is that everyone will give forty hours of service [per week] to the state."

What about salaries? "The average monthly income of a physician is $74 to $80," Dr. Mietus says. And when a Polish doctor retires, his pension is about two-thirds of that.

Furthermore, he can't provide for his family after he dies by buying life insurance. There's no insurance sold in the country—"on the theory that no one should benefit financially from another's death."

Because of this, Dr. Mietus concludes, Polish doctors have a standard answer to questions about what'll happen after they die. It's: "My wife goes to work the following week."

Insurance Agents 'Explain' Doctors' Code to Them

Doctors in one medical society have tried to reduce friction with insurance companies over fees. But what they've done has made new sparks fly.

Members of the Los Angeles County Medical Association want-

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ed to underline their freedom to negotiate with insured patients individually. So they spelled out a statement of principles and sent it to health insurance underwriters. Said the code in part:

"A financial agreement between patient and physician is a right which cannot be abrogated by any third party. However, such agreement cannot be binding on any third party whose responsibility is [to pay] a reasonable and customary fee."

In other words, the medical men said they intended to agree on fees with individual patients, without cutting into the insurance companies' freedom to set payment schedules. But apparently some of the insurance claims agents read the statement of principles another way: as a promise by the doctors to conform to insurance company schedules. This came to light recently when some medical society members charged higher fees to certain insured patients than the agents considered "reasonable and customary."

"Scale down your fees," the insurance men told the doctors in effect, "or you'll be disciplined by your medical society."

"Nothing could be further from the truth," retorts the executive director of the Los Angeles society, Dr. Edward C. Rosenow Jr. "Obviously, any difference between [the fee] the insurance company allows and what the patient and doctor have agreed upon must be paid by the patient."

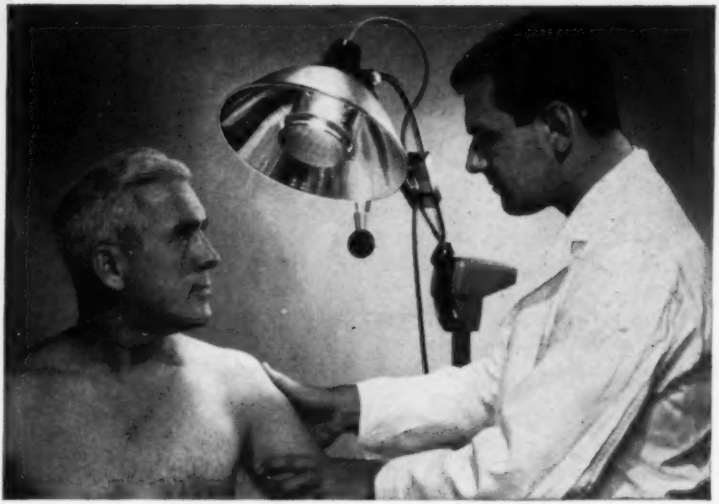
Where did the insurance men go wrong? Clearly, says Dr. Rosenow, in their "completely erroneous and unfair interpretation" of the principles the doctors drew up to set them right.

Price Index That Doctors Distrust May Be Revised

The Consumer Price Index, gauge of national spending, badly needs revision, many doctors have said. Their chief criticism: The index shows far greater rises in the cost of medical care than in the overall cost of living—a disparity the average doctor fails to see matched in his own fees.

Now Labor Secretary James P. Mitchell is adding an influential voice to the call for an index revision. Mitchell recently asked a House Appropriations subcommittee for $4,600,000 to bring the index up to date. At present it's based on the spending habits of 1950. It ought to be adjusted, Mitchell says, to reflect these new conditions:

¶ Incomes are higher and being spent differently. More is being spent on TV, cars, education, and



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medical care. A smaller proportion is going for food.

¶ Families are moving to the suburbs. There they spend less on dressing up and going out, more on outfitting the home.

¶ The population has grown and shifted, so that more people proportionately now live in the Southwest and West.

How might this last point, for example, influence the medical care sub-index? It might mean that the present sub-index weighted doctors' fees too heavily in favor of the more expensive Northeastern cities.

Negro Voted Head of White Medical Society in South

A Negro doctor has crossed the medical color line in Fayetteville, Tenn. Dr. L. M. Donalson, recently elected president of the Lincoln County Medical Association by his white colleagues, thus becomes the only Negro currently to hold such office in a white medical society in the South.

Early in his career, Dr. Donalson was set on moving north as soon as he could afford it. Doctors in Fayetteville urged him to stay. Now Dr. Donalson encourages young Negro doctors to remain in the South, in places like Fayetteville. He cites his experience there as an example. From time to time he asks county authorities for enlarged hospital facilities for Negroes, and he reports: "They've never turned me down."

The biggest such grant the county has made was $100,000 for a hospital that's named after Dr. Donalson. The doctor had suggested naming it after Booker T. Washington. Nonsense, he was told; "Booker T. Washington was a fine man, but he never did anything for Lincoln County."

'M.D.s Make Embezzlers Of Their Aides'

More embezzling goes on in doctors' offices than in the offices of any other professional men. So says practice management consultant John R. Sedgwick. He adds: "This isn't because doctors hire more crooks than other people do, but because they make more crooks from what would otherwise be honest employes."

How are doctors to blame? By making it easy for aides to dip into the till. "Embezzlement is seldom premeditated," says Sedgwick. "The employe finds herself broke and 'borrows' until payday. She pays the money back, and no one is the wiser. The next time she does the same thing; only this time she 'borrows' a little more. This goes on until eventually her pay check

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doesn't cover what she has 'borrowed.' Then she's in real trouble.

"It was that first temptation," he stresses, "that caused her downfall."

Admittedly, it's hard to devise an embezzle-proof system for a one-girl office. But, says Sedgwick: "If I were on a jury and a case of embezzlement came up where the employer had placed too much temptation before the employe, I'd consider the employer as guilty as the employe."

To thwart temptation, Sedgwick recommends that doctors:

1. Pay adequate wages. ("In many offices wages are substandard.")
2. Have every employe who handles money covered with a surety bond.
3. Bank receipts every day.
4. Set up a modern bookkeeping system so that entries can be checked and double-checked.

Blue Shield Plan Pays Dentists, Podiatrists

No longer is Blue Shield strictly the "physicians' plan." Starting at the end of next month, "practitioners" will be the word in New York City. A state law requires nonprofit health plans to pay dentists and podiatrists on the same basis as physicians for any contract-covered procedures the non-M.D.s are legally qualified to do. This, in effect, gives subscribers broader choice of practitioner, although it doesn't increase the range of benefits.

The law establishes, for instance, that a subscriber with paronychia may have it drained by either a licensed physician or a licensed podiatrist—but the plan must pay the benefits that have been set for that procedure.

New York's Blue Shield subscribers are now being notified of the new development, which has its roots in an eighty-year-old law. When passed, the law was generally considered to permit—not compel—Blue Shield to extend payments to non-physicians. Then several years ago dentists insisted they had a legal right to payments. But New York City's United Medical Service, for one, didn't like being told it had to take in the dentists—and went to court to say so. The courts upheld the dentists.

Now dentists and podiatrists—the only "practitioners" the law currently specifies—will be eligible for Blue Shield payments.

So far, New York is the only state that compels Blue Shield and other nonprofit plans to include dentists and podiatrists, although several states have laws that permit their inclusion. END

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Then maintain lasting comfort, free from pain and itching, with time-proven Anusol—1 suppository morning and evening and after each bowel movement. Supplement with Anusol Unguent as required.

Anusol and Anusol-HC contain no narcotic nor analgesic drugs, will not mask symptoms of serious rectal pathology.

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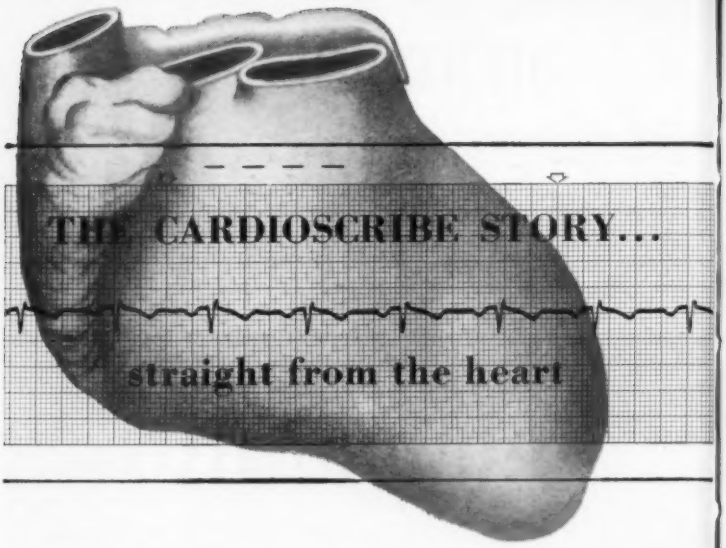

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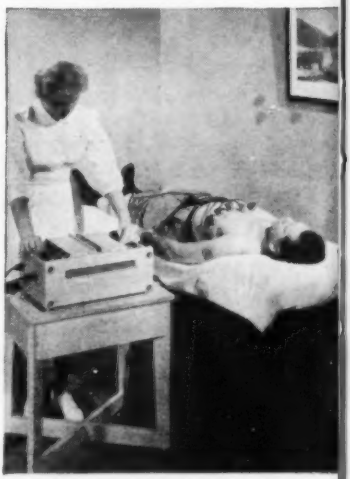

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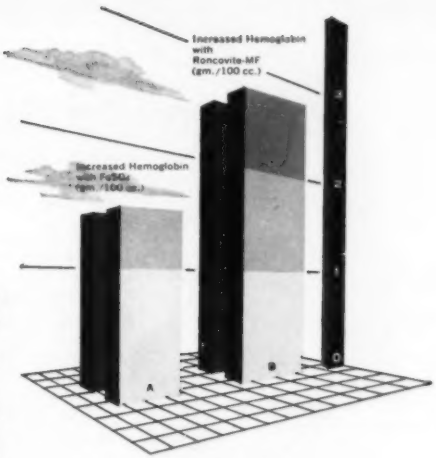

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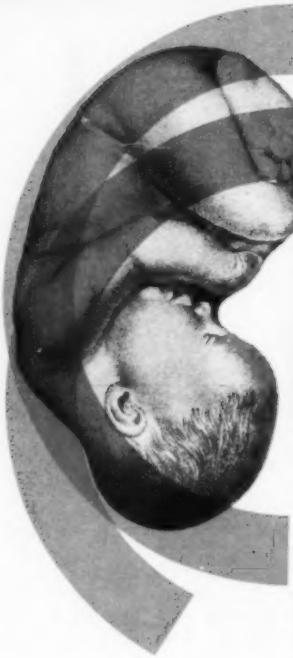

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References: 1. Greenblatt, R. B.: Obst. & Gynec. 2:530, 1953. 2. Pearse, H. A., and Trisler, J. D.: Clin. Med. 4:1081, 1957. 3. Javert, C. T.: Spontaneous and Habitual Abortion, New York, The Blakiston Division, McGraw-Hill Book Co., Inc., 1957, p. 338 ff. 4. Javert, C. T.: Obst. & Gynec. 3:420, 1954. 5. Dill, L. V.: M. Ann. District of Columbia 23:667, 1954. 6. Greenblatt, R. B.: Ann. New York Acad. Sc. 61:713, 1955.

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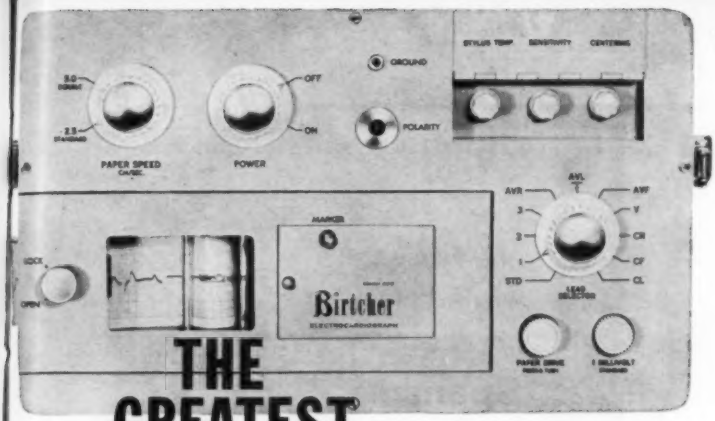

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Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, MAY 25, 1959

How to Pick a Collection Agency

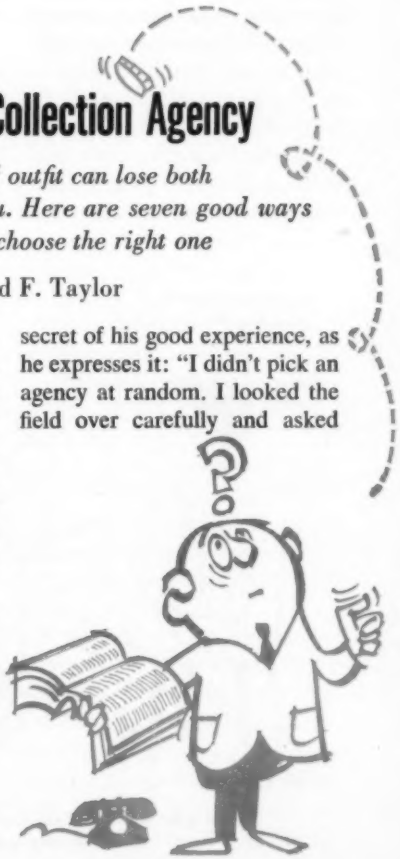
The wrong kind of outfit can lose both money and patients for you. Here are seven good ways to make sure you choose the right one

By Clifford F. Taylor

There's a certain Midwestern doctor who refuses to use a collection agency. "Five years ago," he explains, "I turned my delinquent accounts over to a big-time bureau. They collected only about 10 per cent of the money I was owed. And I'm still dogged by the ill will their 'get tough' tactics generated."

But another Midwesterner tells an entirely different story: "My agency has collected accounts I've considered uncollectible. What's more, they've done it so tactfully that patients don't seem to mind."

Is the second doctor luckier than the first? Not at all. The secret of his good experience, as he expresses it: "I didn't pick an agency at random. I looked the field over carefully and asked



plenty of questions in plenty of places before I finally made my choice."

If you're looking for an agency, better follow his lead. Reputable collectors and experienced physicians agree that the wrong outfit can do you more harm than good. So they heartily approve of asking "plenty of questions in plenty of places."

For the most part, they also agree on the right replies. The consensus is that the organization that will save you both money and patients is one that can answer "Yes!" to the following seven questions:

1. Does the agency operate locally rather than on a nationwide basis?

"Most of the racketeering in the collection business these days is being done by so-called national agencies," says Forrest W. Tucker, who teaches collection techniques for the Medical-Dental-Hospital Bureaus of

"Would it be unethical for you to tell me in plain English what's wrong with my knee?"

America. "A physician can investigate an agency in the community personally. He must take an out-of-state or 'mail-order' agency on trust. And bitter experience has shown many doctors that such trust can be misplaced."

An agency that operates locally puts your future association with it on a personal basis. Because medical collections call for constant cooperation between doctor and agency, that's the most satisfactory basis for such a relationship.

2. Does it specialize in professional accounts?

"I'm a doctor, not a furniture salesman," says one seasoned physician. "My patients are individuals whom I must treat as individuals. If a collection agency isn't sensitive to that fact, it's the wrong one for me."

"The doctor needs an efficient collection service, of course," adds Maynard L. Heacox, executive secretary of the Medical-Dental-Hospital Bureaus. "But that doesn't mean he should use a commercial agency that boasts, 'We treat 'em all the same.' The wise physician chooses a concern that either devotes itself exclusively to medical collections or has a special department for such work."

3. Does it charge as much as 33 to 50 per cent on the amounts it collects?

"Ouch!" you may say. "I'd rather write off an account than give 50 per cent of what's collected to an agency. That's too much to pay a bill collector."

But is it too much? Not according to men in the know. Professional collections require personnel with special aptitudes and training. Such agents require high pay. And they get it from the good collection bureaus—which is why many of the best ones charge up to 50 per cent.

A Detroit obstetrician who pays his agency a 50 per cent fee puts it this way:

"I *could* use a cheaper agency, one that would give me 75 per cent of what it collected. But I'd rather get only 50 per cent—and be reasonably sure I'll deliver the family's next baby."

If an organization quotes you a fee of less than 33 per cent, watch out. Some city agencies with a huge volume of business may do a satisfactory job for less. But they're rare exceptions to the rule.

4. Will the [*More on 218*]

The Facts About Lloyd's Malp

Should you look toward London for professional liability protection? Is it cheaper? Is it safe? These experiences of doctors who have had such coverage may help you decide

BY LOIS R. CHEVALIER

Whenever doctors talk about the high cost of malpractice insurance, somebody always remarks, "Well, what about Lloyd's?" Then a lot of conflicting tales and opinions come from all sides.

There are several reasons for doctors' widely varying impressions of Lloyd's of London. The main one is that Lloyd's isn't a single company selling standard insurance policies. It's headquarters for a crowd of risk-takers—individuals who sign up to take a gamble on a particular project.

For centuries, they've covered their bets without fail. So you know they're going to stay in business. But that's about all you do know. What Lloyd's will do for *you* depends on which syndicate or U.S. agent you deal with. Many of the conflicting tales about Lloyd's simply illustrate the differences among their American representatives.

Thus, almost anything you hear about Lloyd's malpractice insurance may well be true for a given situation, though not for others. In an effort to clarify the picture nationally, MEDICAL ECO-

yd's Malpractice Insurance

NOMICS has been ferreting out some facts about Lloyd's policies in this country. Most of the available facts must be drawn from the experiences of doctors who have had *group* coverage with the organization. But whether you're interested in group or individual coverage, this magazine's findings should help you understand the good and bad points about Lloyd's.

On the surface, there seems to be a strong trend away from Lloyd's. A couple of years ago, eight major specialty societies in the U.S. had such coverage. Five of the eight have now given up their contracts. They've done so in spite of the fact that in most states Lloyd's insurance is much cheaper than that of most domestic companies.

Why have five national specialty societies turned away from Lloyd's? Let's examine their reasons:

Perhaps the strongest criticism of Lloyd's came last summer from the American College of Physicians. It discovered that its rates were being set without considering how few claims the members had actually had. So the A.C.P. gave up Lloyd's in a huff.

During the first five years of their program, there'd been only sixty-five claims and potential claims against the 2,400 physicians covered. The carrier had paid out only $5,000 on the largest claim. And the cost of all the claims, including legal and investigative work, had totaled only $18,000 over the five-year

period. Yet, in mid-1958, the broker announced a premium hike that averaged 40 per cent in the lower limits, because of "the over-all loss experience for this class of business."

The internists were baffled. Their over-all experience was remarkably good. What did the broker mean?

They soon got the answer: Their rates were being set on the basis of *all* the professional liability coverage written by that particular syndicate of Lloyd's. In other words, the internists' rates may have gone up simply because some beauty parlor operator had burned a woman's face.

Another strong criticism of Lloyd's comes from several other specialty societies. They've discovered that Lloyd's runs into problems with the state insurance departments.

Not Licensed Everywhere

In most states, Lloyd's isn't a licensed carrier. So the national group programs are usually administered from one of the states where Lloyd's *is* licensed, such as Maryland or Illinois. Doctors who practice in certain areas must therefore buy their coverage from the administrative headquarters *by mail*; it would be illegal for a broker to solicit business in a state where Lloyd's isn't licensed.

In some of these states, however, the London organization is permitted to solicit high-risk business that domestic companies won't take. There the doctor who can prove that he has been turned down by two domestic companies may do business directly with Lloyd's. But on this kind of coverage, Lloyd's premiums may be higher than those of domestic companies. And the over-all cost may be increased by the fact that the state may put an extra tax on unlicensed carriers' premiums.

Forced to Raise Rates

There's still another problem in states where Lloyd's *is* licensed. Since the state insurance commissioner has considerable discretion over the rates of all licensed carriers, some commissioners have forced the organization to raise its premiums considerably.

The College of American Pathologists gave increased premiums as its official reason for terminating its contract with Lloyd's last fall. [*More on 205*]

Invest in the AIRLINES INDUSTRY?

Rated among the highest for probable performance this year, the airline stocks are worth looking into

BY LLOYD HAAS

Over the last decade, few industries have given investors greater hopes and greater disappointments than the airlines. Airline traffic and total revenues have risen in an almost uninterrupted straight line since the end of World War II. But earnings and stock prices of the major companies haven't followed along.

Today, in fact, Standard & Poor's index of airline stocks is barely higher than it was in 1945. "Profitless prosperity" is the way one financial writer describes the present state of the industry.

But now all that seems likely to change. After years of frustration, the airlines at last seem ready to soar—on jet-powered wings. The next few years will

THE AUTHOR, *a member of the New York Society of Security Analysts, is the research partner in the brokerage firm of Haas, Raymond & Co.*

see all the major lines convert to jets. The industry is committed to spend nearly $3,000,000,000 for new planes and for the new airport, passenger, and safety facilities that jet travel will require.

Thus, in one bold stroke, the industry will improve the speed and comfort of its service more than it did all during the last twenty years. The flying time from New York to Los Angeles will be cut to five and one-half hours. Flying with vibration-free comfort, one modern jet can carry more passengers across the Atlantic in a year than a large ocean liner.

How will all this affect you as a present or potential investor in airline company stocks?

To get the answer, you'll first have to look at the industry's past problems. They are two-fold: regulated fares and stiff competition. Both result from the policies of the Civil Aeronautics Board. Let's take a closer look:

AIRLINE FARES. The airlines being a regulated industry, the prices they can charge are set by

Eleven Selected Airline Stocks

	1958 Earnings Per Share	1958 Dividends Per Share	1958-59 Price Range	Recent Price
American	$1.97	$1.00	33⅜-14⅜	31¼
Braniff	.98	.60	17⅝- 6⅞	15¼
Capital	.23	——	23⅞-10⅜	19¾
Delta	3.00E	.90	36⅜-16¼	32⅞
Eastern	2.31	1.00	46⅛-29⅛	41⅞
National	2.00E	.50	29⅜-14⅛	25
Northwest	3.98	.80	46⅛-10⅛	40¼
Pan Amer.	1.15E	.80	35¼-12¾	32½
T.W.A.	.25D	——	23¼-10½	20⅝
United	4.05	.50	40⅜-21¼	39
Western	1.10E	.80	38 -19¼	35¾

E-estimated. D-deficit.

the C.A.B. Twenty years ago, the average passenger fare was 5.32 cents a mile. At the beginning of last year it was actually lower—5.25 cents a mile. All the while, of course, the airlines have had to pay higher prices for labor, fuel, and equipment. So their growing revenues have gone toward meeting those increased costs, not toward increasing profits.

"It's been a treadmill," comments one industry spokesman. "The airlines have been forced to fly faster and faster just to stay in the same place."

Profits Rose Last Year

Lately the airlines haven't even been able to stand still. Beginning in 1956, their expenses began to outclimb their revenues, and profits fell sharply. Not until last year did they begin to turn upward again.

AIRLINE COMPETITION. The airlines have always had to compete with railroads, buses, and private cars for the traveler's dollar. But now they also have to compete among themselves. A few years ago, the C.A.B. began encouraging the smaller airlines by awarding them new routes, often in direct competition with the "big four" of the industry: American, United, T.W.A., and Eastern.

As a result, more and more empty seats have been riding the sky. In 1951, an average of 70 per cent of all commercial airline seats were occupied. During 1958, this "load factor" was down to 58 per cent.

Enter now the jets:

After operating jets between New York and Europe last winter, Pan American reports that its planes flew 90 per cent full. Pan Am's normal winter load factor: 50 to 60 per cent.

American Airlines, using jets only since January, finds that the planes are flying "virtually full." This compares with a 65 per cent load on its piston-powered craft.

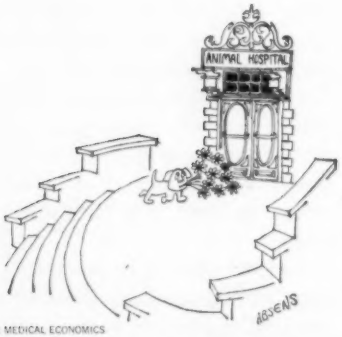
Jets or no jets, air passenger travel is expected to increase along with the pick-up of business in general. According to one long-range prediction, the airlines' passenger business will double by 1965, triple by 1975. And revenues may grow even faster, because the C.A.B. is easing its tight rein on airline fares.

In 1958 the C.A.B. permitted two rate hikes totaling about 10 per cent. Early this year, it al-

lowed a jet surcharge. The board is now studying a request by the airlines for a further rate increase. Its decision is expected some time this summer.

Because of the higher rates already in effect and the growing boom in air travel, investment analysts look for a big boost in airline profits this year. If the C.A.B. should allow another fare increase, profits would go still higher.

To be sure, the airlines won't share equally in those higher earnings. There are big differences in their ability to finance the switch to jet power and to capitalize upon it. The biggest gains will probably be scored by those companies already flying jets—at least until their competitors are similarly equipped.



Dividends probably won't rise along with earnings. Since the airlines need lots of money to finance their new equipment, they'll be slow to increase payouts to stockholders. Thus the lure of airline stocks lies in capital gains.

Prices Are High

This lure has caused the airline stocks to go up quite a bit in recent months. As you'll note from the table on page 74, most of them are selling at or near their 1958-59 highs. Yet some still offer good values.

Here are thumbnail sketches of five leading companies in the industry:

American Airlines operates the largest domestic air system in the country. American already has jets in the air. It's expected to have a total of 110 by 1962. The company is in good financial shape and can probably complete its switch to jet power without issuing new stock, though it did have to issue some bonds. American faces strong competition on its routes but has the edge in equipment over its rivals. Though hit by strikes last year, American showed record earnings of $1.97 a share. Earnings

are expected to rise sharply in 1959. Recent price: 31¼.

United Air Lines is the second largest domestic company. Last year it drew traffic from strike-bound rivals, and its earnings shot up to $4.05 a share—nearly twice those of the year before. United is behind some of its competitors in jets; it doesn't expect to put the first one in service until this September. So United's earnings are expected to drop in 1959. But the company can finance new jets, and its earnings are likely to pick up once they hit the skies. Recent price: 39.

Jets Are Promising

Eastern Air Lines is the principal north-south carrier in the eastern part of the U.S. The line faces stiff competition because of recent route awards to other companies. Until recently, one of them, National, was operating jets in competition with Eastern's piston planes on the profitable New York-to-Miami flight. Now Eastern is operating jet-powered planes, and these should help strengthen its competitive position. Last year Eastern earned $2.31 a share even though it was hit hard by strikes. This year, free from strikes and flying its new planes, it should do considerably better. Recent price: 41⅞.

Pan American World Airways operates the largest air transportation system in the world, serving some seventy countries. It also operates a missile range for the Air Force at Cape Canaveral. Pan American started trans-Atlantic jet service last October; it's expected to put more jets into service this summer. Earnings for 1958 were $1.15 a share. With new jet equipment coming, the company is expected to do much better in 1959. Recent price: 32½.

Trans World Airlines, the fourth largest domestic air carrier, also serves twenty-three foreign cities. T.W.A. has lost a lot of business to other lines flying jets in competition with its piston planes. But now the company has just put its first jets into service between New York and the West Coast. It expects to have trans-Atlantic jets flying by this fall. T.W.A. may have some difficulty financing the change to jets. Last year it reported a loss of about 25 cents a share. This year, if its traffic picks up as expected, it may earn a profit. Recent price: 20⅝. END

HOW THE Keogh Bill COULD CHANGE YOUR LIFE

At every session of Congress since 1951, Representative Eugene J. Keogh (D., N.Y.) has dropped the bill bearing his name into the hopper. At every session, Congress has let it die.

Will 1959 break the pattern? It's possible. The measure has already passed the House. Chances for Senate passage are rated good —the best in the bill's eight-year history. But there's hard sledding ahead. Backers of the bill say it needs all the support it can get.

As you know, the Keogh bill would permit you to set aside some of your savings in a retirement fund. And you wouldn't have to pay Federal income taxes on such money until you began withdrawing it.

Is the right to defer taxes on a part of your savings really worth fighting for? Do doctors need something like the Keogh bill to encourage them to save for retirement? If the bill should become law, would you and your colleagues take full advantage of it?

To find the answers, The Bank of New York recently polled several thousand physicians, dentists, and lawyers in Manhattan and Long Island. And Boston's Old Colony Trust Company sent an identical questionnaire to thousands of other professional people in Massachusetts. Among the responses were over 2,600 from physicians.

From a study of the survey

High taxes have kept two-thirds of the profession from financing their own retirement plans, this survey indicates. Here's the difference the Keogh tax deferment would make

BY M. J. GOLDBERG

findings as they apply to doctors only, the following conclusions emerge:

¶ Only a minority of practicing physicians are now making personal financial plans for retirement.

¶ Virtually all physicians favor the Keogh bill.

¶ Just about every physician expects to participate in a tax-deferred retirement plan as soon as the Keogh bill becomes law.

Those findings hardly come as a surprise. What's surprising is the unanimity of opinion among the surveyed medical men—and also the vigor of their comments. The response suggests that U.S. doctors have been thinking long and hard about the role a tax-deferred pension plan could play in their lives. Here's a detailed analysis of the three major findings:

Only about one in three doctor-respondents is now making personal plans for financing his retirement years.

Why so few? High taxes are blamed as the principal reason. Some typical comments:

"The progressive tax schedule hits my upper income brutally, making it impossible for me to save money . . ."

"Sure, I could save for my retirement—if I could 'deplete' myself like an oil well . . ."

"Last year, I paid state and Federal taxes of about $20,000. Every quarterly tax payment seems to be a struggle. I'm not

saving one-tenth of what I did ten years ago, when my income was much lower."

Such comments and many similar ones make it clear that the doctors who don't save money aren't simply careless or thoughtless. They're seriously concerned about their winter years; many are bitter about their inability to plan ahead. As one respondent puts it:

"It looks as if I'm going to be in the unenviable position of being 'too rich' to qualify for welfare and 'too poor' to be decently self-supporting. I'll either die with my boots on or starve."

How satisfied is the one man in three who now sets aside funds for his retirement? Not very, according to the survey responses. The big trouble has been inflation.

"Because of the rise in living costs," says one doctor, "the beautiful plans I made twenty years ago are now hopelessly inadequate. My annuities are maturing. But they won't buy half of what they would at the time I bought them."

Adds another man: "I *thought* I had a planned retirement program when I started buying annuities ten years ago. Now it looks as if they won't be nearly enough to live on."

Of the doctors polled, about 12 per cent are working either part- or full-time for a company, and are therefore covered by a private pension plan. But few of them feel that any such plan will

What the Keogh Bill Provides

The Keogh bill is designed to permit you to set retirement savings aside—free of income taxes—while you're working and in a high tax bracket. The income and capital gains earned by those savings will also accumulate tax-free. The money will be taxed only as you draw out payments after age 65, when your tax bracket will probably be much lower.

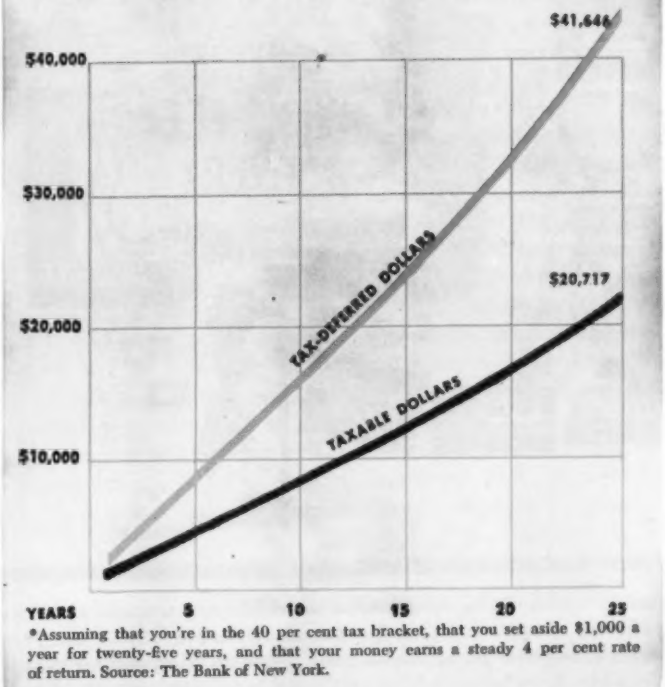
In general, the set-aside is limited to 10 per cent of your net earnings from self-employment, up to a maximum of $2,500 in any one year and $50,000 over a lifetime. The money may be held in a bank-trusteed fund or in an annuity policy issued by a life insurance company.

provide a satisfactory retirement income. "Ridiculously inadequate," is the way one employed doctor describes his company's pension plan.

Even so, a number of the respondents report they've accepted jobs largely because of this fringe benefit. One young man admits that the fate of the Keogh bill will determine whether he'll concentrate on private practice or seek a salaried job.

More than 98 per cent of the doctor-respondents favor the Keogh bill. [*More on 229*]

How Savings Would Grow in a Tax-Deferred Fund*



*Assuming that you're in the 40 per cent tax bracket, that you set aside $1,000 a year for twenty-five years, and that your money earns a steady 4 per cent rate of return. Source: The Bank of New York.

THIS ARTICLE *is the second of several based on a new* MEDICAL ECONOMICS *survey of office visit fees. The first article, in the May 11 issue, reported charges for initial, routine, and follow-up visits, and for annual check-ups. Later articles will report usual fees for injections, the amount*

BY HUGH C. SHERWOOD

Suppose a patient came to your office with a cold or some other condition for which you'd ordinarily charge a routine office visit fee. Suppose, in treating him, you decided you'd better prescribe a special diet. Would you charge extra?

If you would, you're out of step with your colleagues. MEDICAL ECONOMICS recently asked 1,706 of them if they'd charge more than their routine office visit fees for doing any one of more than forty different office procedures. Over 90 per cent of the surveyed men said they'd charge nothing extra for prescribing a special diet.

But such near-unanimity is rare. The accompanying tables prove it. They show there's a big difference of opinion among U.S. physicians on whether to tack on an extra charge for certain office procedures.

There's also little agreement on how much, if anything, to charge extra. So where there appears to be no "usual" extra fee, you'll find none listed in the accompanying tables.

What about differences among doctors in various fields of practice? Here's one significant difference: The general practitioner is more likely to charge extra for a given office procedure than the specialist is.

Of course, there are exceptions. More internists than G.P.s get an added fee for injections, vaccinations, and antitoxins. And surgeons seem more apt to charge extra for strapping ankles, knees, and the like. But for most other procedures the G.P. leads in extra charges.

The reason? It emerges from further analysis of the survey findings:

The less a man charges for a routine office visit, the more likely he is to charge something extra

for an added service. To illustrate:

Some G.P.s charge only $2 for a routine office visit. And most such men say they charge extra for all but seven of the listed procedures. Among the seven are such simple services as cleansing wounds and removing stitches.

On the other hand, most of the surveyed OB/Gyn. men charge at least $5 for a routine office visit. As a result, most of them charge extra for only five of the listed procedures: polio shots, sutures of soft skin tissues, minor cauteries, tissue biopsies, and Pap tests.

More▶

THESE SERVICES ARE USUALLY COVERED

A majority of the surveyed doctors who do the procedures listed below don't charge more for them than their routine office visit fees.

Procedures	% of Surveyed M.D.s Who Don't Charge Extra	Usual Extra Charges of Other Surveyed M.D.s
EXAMINATIONS		
Abdominal	92%	$1-2
Pelvic	69	1-2
Rectal	79	1-2
Vaginal	71	1-2
INJECTIONS		
Allergy	54	1-2
Fatigue	55	1-2
GI spasm	51	1-2
Nausea in pregnancy	52	1-2
REMOVAL OF FOREIGN BODY		
Intracutaneous	52	*
Subcutaneous	51	*
OTHER PROCEDURES		
Cleanse wound	77	1-2
Check for breast cancer	85	*
Prescribe special diet	94	1-2
Remove stitches from minor wound	88	*
Remove wax from ears	67	1-2

*Extra charges vary too widely for any to be called "usual."

THESE SERVICES USUALLY COST EXTRA

A majority of the surveyed doctors who do the procedures listed below charge more for them than their routine office visit fees.

Procedures	% of Surveyed M.D.s Who Charge Extra	Usual Extra Charges
INJECTIONS		
Anemia	58%	$1-2
Arthritis	57	1-2
Infection	65	1-2
Inflammation	60	1-2
Diphtheria	52	1-2
Pertussis	52	1-2
Tetanus	57	1-2
Triple shot	54	1-2
Polio shot	60	3-up
Smallpox	60	*
REMOVAL OF FOREIGN BODY		
From eye	61	*
From nose	52	*
From throat	57	*
STRAPPING		
Ankle or wrist	66	*
Knee or elbow	57	.50-1.50
Hip	58	.50-1.50
Shoulder	61	.50-1.50
OFFICE SURGERY		
Excise ingrown fingernail	82	5-10
Lance and drain boil	77	*
Minor cautery	65	*
Suture of soft skin tissue	91	*
Tissue biopsy	86	*
OTHER PROCEDURES		
Desiccate skin	65	*
Diathermy treatment	57	2-3
Fluoroscope patient	72	*
Papanicolaou test	66	5-10
Set dislocated digit	86	5-10
Treat first-degree burn	54	*

*Extra charges vary too widely for any to be called "usual."

All 1,706 doctors surveyed were also asked this question: Suppose, while treating one condition during a routine office visit, you found it necessary to perform two rather than just one of the listed procedures. Would you charge extra?

Some 45 per cent said they would. Their main reason: The extra time the extra procedure takes is worth money. And patients should pay for extra care.

"After all," argues a Wyoming G.P., "you can't get two articles for one cent extra at a one-cent sale."

Still, most of the surveyed doctors *don't* charge extra for performing two procedures instead of just one. Some say patients wouldn't accept the extra charge. Others argue that they treat the whole patient, not just various parts of him.

One New Hampshire G.P. charges a fixed fee for every routine visit, no matter what it entails. He explains his system this way:

"My fee is for my judgment, not for the particular techniques I use or the procedures I perform." END

The mother was simply historical

At 3 A.M. on a wild winter night, a mother phoned to ask me to come see her child. "I think he has pneumonia," she said. "We're quite worried about him—we've already lost two children."

Needless to say, I went at once. The child had chicken pox. In taking a history, I asked how old the other children had been.

"One was two months and the other was three months," she replied.

"And what was the cause of their passing away?" I asked.

"Both were miscarriages," she answered.

—L. P. LAPIN, M.D.

For each previously unpublished anecdote accepted, MEDICAL ECONOMICS *pays $25 to $40. Address: Anecdotes, Medical Economics, Inc., Oradell, N.J.*

You Need a Personnel Policy

By Horace Cotton

Some doctors don't have one. Others have one but haven't announced it. Both types have been asking me for the simplest statement of good personnel policy I've seen. Here it is, as recently adopted by several Southern partnerships:

1. Employes will be granted two weeks' annual vacation with pay per calendar year. Newer employes will receive one day of vacation for each month of service in the calendar year in which their employment begins.

2. Occasional absence for good cause will be permitted without loss of pay. Approval of requests for such time off will be affected by the employe's record of prior absences.

3. Employes with more than a year's service who are incapacitated will be paid in full for up to two weeks' absence; they will receive half pay for up to an additional two weeks.

4. Employes with less than a year's service will receive up to one week's pay for absence necessitated by sickness.

5. This office is usually closed on legal holidays. If it's necessary for any employe to work on such days, she'll get equivalent time off.

6. Overtime is not paid for. If frequent or prolonged overtime is necessary, it will be compensated by time off at the convenience of the office. END

THE AUTHOR *heads the professional management firm of PM–Southeast, with headquarters in Southern Pines, N.C.*

Northern Office With Southern Charm

Wish your office were more relaxing for all concerned? Then consider the warm atmosphere these surgeons have created

By Kenneth and Katherine MacDonald

Stone, glass, and plywood make up the exterior of the Durkin-Banfield clinic. Wing at right is rented to a dentist, who has his own entrance.

A stream of water rambles through a garden court. Along the stream rises the lush green of tropical plants.

A Hollywood setting? No, it's the Southern-style waiting room of two physicians in Tacoma, Wash.: Dr. L. Stanley Durkin, a neurological surgeon, and Dr. Ernest E. Banfield, a plastic surgeon.

About three years ago, they decided to move out of their old quarters in downtown Tacoma and build a new office away from the center of the city. Since their practices are almost entirely consultative, they agreed they wanted an office with a relaxing atmosphere that would help ease the tensions of waiting patients. "Above all, we both felt a sterile clinical atmosphere would be most undesirable," the doctors say.

Result: an office building that's laid out in a manner more common to Mexico and South

Light, warmth, and water grace the reception area (in color below). Note skylight and high windows.

Garden court in the center of this medical office gives patients a pleasant place in which to wait—and doctors something pleasant to look at.

America than it is to the Pacific Northwest. The consultation rooms look out on a patio-like garden court that abuts the pleasant reception area where patients wait.

Privacy isn't a feature of this layout. But the doctors say that's usually no problem. On the few occasions when it might be, the surgeons simply close the curtains between their consultation rooms and the garden court.

Before they moved into their Southern-style building, Drs. Durkin and Banfield wondered whether patients would shy away from the unconventional atmosphere. Happily, they haven't.

"When a patient's appointment time comes up," says Dr. Banfield, "he'll sometimes tell me that some other patient has been waiting longer—that he'd just as soon enjoy the scenery a few minutes more." END

NEXT TIME YOU SELL YOUR HOUSE

A doctor I know put his home up for sale last fall. He wanted to get a line on its market value. He thought he might sell *if* he could get a high enough price.

Before it had been listed two months, his broker found a prospective buyer. But by this time the physician had decided to hold on. "We've lived here a long time," he explained. "And we've decided it would be foolish, at my age, to go to all the trouble of resettling." So he turned down the offer, even though it was a good one.

What the doctor didn't realize was that as soon as the real estate agent turned up with a buyer willing and able to pay his price, a broker's fee was due. The lesson cost him 5 per cent of the valuation he had put on his place.

So next time you're thinking of listing some property for sale, be sure you really *want* to sell it before you give it to an agent. If he finds a buyer, you may have to pay the broker's commission even though you decide not to sell.

—JOSEPH BERMAN, LL.B.

Interested in more complete care for your patients, a shorter working day for yourself? Then take a tip from this doctor's experiences

How I Cut Down My Question-Answering Time

BY WILLIAM G. CROOK, M.D.

Do you feel frustrated because you never have enough time to answer your patients' questions? If so, I think you'll be interested in my solution to the problem.

I began practice as a pediatrician ten years ago; and within a few weeks I had a crowded office. Within a year, I was working twelve hours a day, seven days a week. And I wasn't doing my job well.

Dozens of mothers with countless questions were always at hand. Why wouldn't Susie eat? Why wouldn't Sally obey? How could Johnny be broken of his bed-wetting habit? How should Mary be told she was adopted? And so on and on and on.

I tried to listen patiently and to answer all questions fully. After all, such things are vastly important to the typical parent (and to the child too). But I was kept so busy at this part of my job that when a child with a severe acute illness like erythroblastosis, meningitis, or diabetic acidosis came

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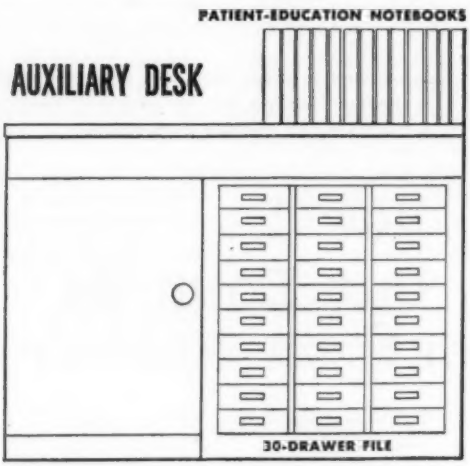
THIS ARTICLE *has won one of the* 1958 MEDICAL ECONOMICS *Awards for its author, a pediatrician-partner in The Children's Clinic, Jackson, Tenn.*



READY-MADE ANSWERS *for patients are always handy in this desk. From the file drawers, doctor hands out fact sheets on common ailments. Notebooks (top) say it in pictures.*

in, I had little or no time to treat him. So I'd generally have to refer him to a near-by medical center. Prevented from using all my knowledge and training, I felt more and more frustrated.

In 1952, a partner joined me; and by 1954 there were three of us. Even so, the basic problem remained unsolved. We were now able to handle many of our sick, complicated hospital patients. But we knew that as children's physicians we had to treat and reassure parents as well as minister to their children. Trying to do both jobs involved us in a rat race that we seemed unable to win.

Clearly, we couldn't cut down the time it took to treat the children. So we looked for a way to reduce the question-answering time spent with our other patients, the parents.

What if we were to write down

some often-called-for answers, then hand them out as needed? That would save time, all right. But could we take this short cut —plus a few other short cuts we'd been thinking about—and still give people the personal attention they expect?

Here's what we did to find out:

Fast Facts

First, we invested in an automatic duplicating machine and an electric typewriter. With this equipment we began mass-producing answers—by the hundred —to questions we'd been hearing for years. At the start we made ourselves two rules:

¶ Write for the parents in simple, concise language.

¶ Keep each answer to a page.

That was three or four years ago. By now we have more than a hundred prefabricated answers on subjects ranging from bedwetting to birthmarks, from chicken pox to colic.

We keep these fact sheets where we can reach them, in an ordinary thirty-drawer file in the consultation room (see accompanying illustration). We use paper of several different colors for our mass-produced answers. That way, we can put discussions of four or five different topics in a single small drawer. The colors help us locate the right answer sheets without fumbling. By now we're so at home with this file of answers that, while we're talking with a patient, we can pull out guidance material in seconds.

But what happens then? A skeptical colleague once asked me how many extra maids we need "to sweep up the instruction sheets that people drop in the hallway as they go out."

Admittedly, not everyone reads the stuff. But enough people do read it to make our working day a lot easier.

For example, we don't get so many follow-up phone calls as we used to. A mother would call up a few hours after an office visit, to ask us how many days chicken pox is contagious, or how much aspirin she could give to her youngster with roseola, or what to do if her child had another convulsion. Such calls are much rarer now. Why? Simply because we've tried to anticipate the questions in the printed handouts.

We also wanted another timesaver that could answer questions for us right in the consulting room. So we took some of

the mass of printed material that flows into every doctor's office and put it to work.

We started saving a diet list here, an anatomical chart or photograph there. We kept some of the instructional material put out by drug houses, and we clipped occasional articles and ads from magazines. Always, we favored illustrations—anything to make a point visually.

We sorted this bulk of material into some twenty notebooks, by subjects. The notebooks are kept within arm's reach, on an auxiliary desk (see drawing) immediately behind the doctor's desk. Here's how we use them:

While we're examining a child or handling a telephone call, we give a mother the appropriate notebook to look at. We let the drawings and charts speak for us while we're busy at something else. Or as we discuss an ailment

"When Mrs. Black leaves you for Dr. Smith, he's stealing patients. When Mrs. White leaves Dr. Smith for you, she's wisely putting herself in competent hands . . . Do I have it right now?"

with a parent, we may pull out a notebook to illustrate a point.

For example, say we're dealing with one of the common foot problems of children, pronation. We take the "foot" notebook off the desk and show the mother a picture of an infant with pronated feet. Then we show pictures of an infant sitting or sleeping in various positions that may lead to pronation. Finally, we show the mother a picture of the type of shoes we want her to buy.

Booklets to Take Home

So far, so good. The notebooks and the one-page fact sheets are fine for helping us treat a specific ailment. But parents often need more general guidance. So we've laid in some literature in capsule-size doses: Public Affairs pamphlets.

As you probably know, these booklets talk in layman's language about many different medical and health topics. The assortment we chose ranges from a discussion of mental health to "How to Tell Your Child About Sex." The bulk copies are in a file behind the receptionist's desk. There's also a set of single copies in our own office.

The pamphlets cost us about 18 cents each, ordered in lots of several hundred.* When we "prescribe" a certain issue—say, "Understand Your Child From 6 to 12"—the aide hands the mother the pamphlet, and a 25-cent charge is added to her bill. Reason for the charge: It gives us a bookkeeping check to be sure she actually gets the material we want her to have. And we figure that the person who pays for a booklet is more likely to read it.

Then we added a final item to our supply of ready-made answers. We bought books, some two dozen of them, written for the layman. As titles, we selected the subjects we'd been spending the most time talking to parents about. Our books cover adoption, allergy, behavior problems, on down the alphabet. The books stand on shelves at the receptionist's desk.

Rx: Read Chapter 6

We've read the books ourselves, of course, to make sure we and the authors see eye to eye. We prescribe selections from a book just as we prescribe medicine.

At first this presented a prob-

*Obtainable from Public Affairs Pamphlets, 22 East Thirty-Eighth Street, New York 16, N.Y.

lem: Many of the books that left the office were never returned. So we set up some lending-library rules. A parent signs for a book for one or two weeks—occasionally longer. Fines of 50 cents a week for overdue books are added to her bill.

There you have my system for taking the pressure out of a crowded day. You can see why I'm sold on it. We can give the parent more guidance than she got from us before. And we give it in less time per patient than we were spending in the old days.

Interested in following suit? It's easy to begin. Just line up your answers before patients ask the questions. END

WHAT'S A FAIR RENT?

When one doctor rents office space to another, they sometimes have trouble deciding on an equitable rent. In such cases, I usually recommend that the tenant pay a proportionate share of the costs of office ownership *plus* 5 per cent of the owner's cash investment in the rented space.

Suppose a doctor's planning to rent out half of an office building that cost $50,000 to build. Suppose the lot it stands on cost $10,000. Suppose the owner invested $20,000 cash in the property and raised the rest through a $40,000 mortgage with an interest rate of 5½ per cent. Here, then, is what I figure the tenant should pay:

Half the annual depreciation on the building	$ 750
Half the annual interest on the mortgage	1,100
Half the annual cost of insurance, maintenance, repairs, taxes, and utilities—for example	1,500
5 per cent of half the owner's cash investment	500
Annual rent	$3,850

—JOHN C. POST

What Wins Patients?

Try This Test and See

Do you use every possible technique to inspire their confidence in you? A 'yes' answer to each of these nine questions gives you a perfect score

By Charles Miller, M.D.

Before becoming a psychiatrist, I spent several years as a G.P. It wasn't long after I first hung out my shingle that I discovered I was woefully unprepared to manage an important aspect of practice. I knew precious little about handling patients—and no medical text could help me.

Part of my trouble, obviously, stemmed from youth and inexperience. But my years in psychiatry have taught me that a doctor's age hasn't too much bearing on how the patient accepts him. Some beginners step into the doctor-patient relationship as if born to it. Some older physicians still seem to lack the ability to create confidence.

Do you sometimes sense an "I dare you to cure me" attitude in your patients? If so, here are some important questions you'll do well to ponder. I've found

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Rheumatoid arthritis (male, 63)

"Full relief, resumption of work." (Dosage: one tablet t.i.d. to one tablet daily)

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Urticaria (one week after tetanus antitoxin) -- female 26

"After 4 tablets stat, required no further treatment. Good results, sense of well being."

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"Marked diminution of symptoms since onset of therapy." (Dosage: one tablet t.i.d.)

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Exfoliative dermatitis (male, 84)

"Marvelous results - skin completely cleared except over ankles where there is superimposed stasis."

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SAINT LOUIS, MO. FEB 16 10 AM 1959

Herpes Zoster (female, 55)

"Results are outstanding....Pain decreased after first three doses. Zoster dried in 4 days." (Dosage: one tablet t.i.d.)

Schering

that they add up to a valuable refresher course in the art of inspiring confidence:

1. Do your surroundings reflect your status as a successful professional man?

Recently, a woman I know came down with a violent earache while in a strange town. A storekeeper recommended a certain Dr. M. His office, it turned out, was above a hardware store. The stairs were dusty, the corridor walls dirty and peeling. My friend went as far as the landing, peeked in the door of the reception room—it was shabby—and retreated.

Her reason, as she explained it later: "The place looked as though it rented for about $25 a month. So I figured the man must not be making much money and couldn't be a very good doctor." An illogical conclusion? Sure—but it's human.

The plain truth is that patients *are* apt to judge a doctor by how prosperous he seems. They respect the man who has a presentable car; who wears well-tailored business suits, with conservative ties, shirts and shoes; and who works in a comfortable, modern office.

2. Do you give enough of your time to each patient to win him over?

Granted, you may be too busy to let everyone talk himself out. But I've found it a sound idea—especially with new patients—to sit back every so often and say: "Now, Mr. Jones, is there anything else you want to tell me or ask about?" As you no doubt know (but as we all sometimes forget), the thing that's bothering a patient most is often the thing it's hardest to get out into the open. But once he's told you—and you've shown your ability to cope with it—he's apt to be your devoted follower, even if he hasn't quite trusted you up to this point.

A colleague once gave me a perfect example of what can be achieved when the patient is allowed to talk himself out. As a beginning G.P., my friend was visited by a woman who was pitifully choked up with asthma. For six months, she said, she'd been going regularly to an allergist, but he'd made little progress in helping her.

The young G.P. encouraged her to give him all the details of her case; he had no other appointments that day. As she was leaving, she said, "Doctor, you've

spent more time with me this morning than that specialist has in all my visits put together." When she returned a week later, she told the young G.P. gratefully that she was feeling better than she had in years.

3. Do you inspire confidence by anticipating symptoms and asking about them?

For example, if the first symptoms the patient recites to you suggest diabetes, do you take the ball and carry it on your own? Do you ask specifically about water-drinking, weight loss, itching, and polyuria?

"What are you—a mind reader?" a patient once asked me during a history-taking session of this sort. "I was just going to tell you about that."

To my mind, such leading questions about symptoms impress the patient far more than the traditional, start-to-finish type of history-taking. They're a perfectly sound way to help the patient realize the extent of your special knowledge and training.

4. Do you give the patient your undivided attention?

To put it another way, any doctor speaks with more authority if he listens first. I once sought medical care from an internist who taught me this lesson in reverse. He repeatedly broke off

the conversation to search for his stethoscope or some other instrument. He'd ask the same question two or three times. He fidgeted, played with his pencil, kept looking at his watch. He allowed frequent interruptions for phone calls, then came back to me with "Now, where were we?"

After all this, I naturally had little faith in the diagnosis he finally got around to making. His mind had been on too many other things.

Sometimes a doctor fails to pay close attention because he's already made up his mind about the treatment he's going to recommend. As a warning against doing this, consider the experience of a certain banker friend of mine:

He developed an ulcer and went to the town's top gastroenterologist. After a question or two, the doctor launched into a sermon on the evils of the predinner cocktail. He told my friend just how to reduce his alcohol intake. It happens that the banker is a total abstainer. But the specialist was so busy doing most of the talking that he never found out that little fact.

5. Do you use the oldest confidence-giving maneuver in the world: the laying on of hands?

Many doctors, I've observed,

...and one to grow on

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have a resistance to direct contact—to feeling the spot that hurts, palpating the abdomen, and so on. It seems, unconsciously, a seductive act to them if the patient is a female, and homosexual if the patient is a male.

Actually, physical contact between the doctor's hand and the patient's body is a powerful gesture when done with self-assurance. When a doctor takes a pulse, for example, he does more than tally the beat; his touch transmits a feeling of strength and confidence.

6. Do you convey assurance by giving an ailment a specific label and by being specific about treatment, too?

With some patients, it may be all right to wrinkle your brow and say: "Darned if I know what *is* wrong with you!" But with others, that sounds like an admission of incompetence.

Early in my career, I learned

in vaginitis

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In *habitual abortion,* resulting from inadequate corpus luteum activity, Enovid supports the decidual endometrium and therefore encourages continuation of the pregnancy.

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Dosage in Threatened Abortion

Two or three tablets daily on appearance of symptoms. This dosage may be reduced to one or two tablets daily when symptoms disappear. The reduced dosage should be continued to term and an increased dosage given if symptoms reappear.

Dosage in Habitual Abortion

One or two tablets daily as soon as pregnancy is diagnosed and continued without interruption at least through the fifth month. Enovid may be safely continued to term if desired.

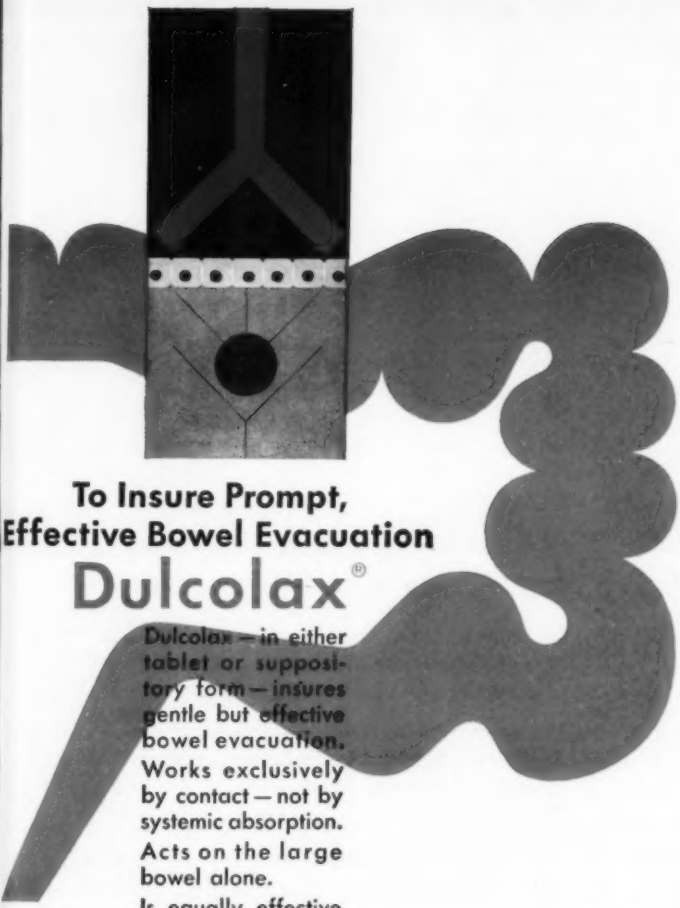
SEARLE / *Research in the Service of Medicine*

when in doubt to translate the principal symptom into a medical term: A pain in the neck became myositis, headache was cephalalgia, and so on. Such noncommittal labels help bridge the awkward gap between first visit and final diagnosis. And they make the patient feel more secure in the meantime.

Even before you make a firm diagnosis, you can show you're in control of the situation. You can give the patient certain longed-for reassurances. About what? Well, studies have shown that the typical patient is apt to be afraid of one of four things: malignancy, venereal disease, contagious disease, or disability. And for certain symptoms, there's a fifth fear: of impotence or sterility.

Knowing this, as a family doctor I used to try to anticipate each patient's probable fear. If I could honestly do so, I allayed the fear even before the patient brought it up. I might say casually: "Well, anyway, it's not catch-

"I think you're just plain inconsiderate—taking out all that life insurance on yourself and none on me!"



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ing." Or: "The tests will show whether you have kidney stones or some sort of inflammation. But in any event, it's certainly not a tumor."

Be Decisive

Such reassurances inspire confidence. So can the doctor's manner when he prescribes treatment. I'll never forget the look of concern on one patient's face when he saw me write a prescription, tear it up, and then start over. He was probably wondering whether I'd almost prescribed the wrong dosage.

After that, I tried always to appear decisive in writing an Rx (perhaps having checked the manufacturer's recommendations while the patient was getting dressed in the next room). I made a little show of copying the Rx for my files, and I paused to read over the patient's copy before handing it to him. Such deliberate little gestures take only a moment, but they create a picture of careful attention to every detail.

Another way to suggest self-assurance is to be definite in your instructions. You can say exactly

how to put on a mustard plaster, or exactly what exercise to take.

Better yet, when appropriate, why not put your instructions in writing? "Cut down on meats and eat plenty of fruit" is the sort of vague dietary advice, for example, that's easily given, easily forgotten. That's why many successful doctors I know give their patients a detailed diet list, handwritten or typed as though specially compiled for that particular situation.

7. Do you show you're in charge of the situation by specifying a time for follow-up?

Here, I've found it best to name a week, a day, or perhaps even an hour. I might say, "Please telephone next Monday between 10 o'clock and noon to let me know how you're feeling." Or I might ask the patient to make an appointment to come in again during the week of the fourteenth. In my experience, such definiteness makes it more certain the patient will check in as promised—and will stick to the prescribed regimen in the meantime.

8. Do you take care to recommend a consultant in a way that doesn't reflect on your own competence?

As a brand-new G.P., I felt I had to walk a narrow plank in the matter of referrals. Failing to call in a consultant might cause trouble. But a premature call for help might be interpreted to mean that I had no confidence in myself.

This dilemma didn't bother me if some complicated procedure was called for. For instance, I never felt embarrassed at asking a specialist to do a gastroscopy. But asking a consultant to recommend, say, an ointment for a skin rash was quite a bit more tricky.

In such cases, I found I could save face by telling the patient something like this: "You have a rather unusual form of dermatitis. Of course, you'd like to get over it as quickly as possible. So let's get the recommendation of a specialist who spends all his time on just this sort of thing."

9. Do you decide whether a patient wants orders or will respond best to suggestions—and do you handle him accordingly?

Is the patient on the passive side—likely to feel most secure when he's following instructions? Then why trouble him by asking him to help make decisions? If he has a hernia, you can say, "You

Controls compulsive eating

Clinical studies reveal that emotionally disturbed patients comprise the largest proportion of obese patients.[1] Bontril curbs the compulsive desire to eat by promoting emotional stabilization. Thus, better patient cooperation is assured.

1. Young, C. M., et al. (Study made in School of Nutrition, Cornell University), Am. Pract. Dig. Treat., 6:685, 1955.

Each tablet contains:

Dextroamphetamine Sulfate	5 mg.
Methylcellulose	350 mg.
Butabarbital Sodium	10 mg.

Dosage is flexible:

½, 1 or 2 tablets once, twice or three times daily. The usual dosage is one tablet upon arising and at 11 A.M. and at 4 P.M.

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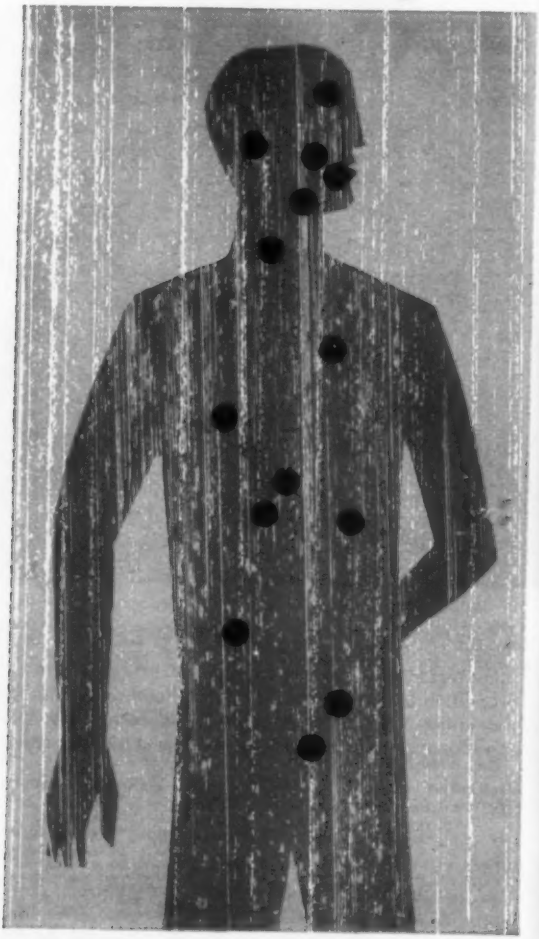

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must have an operation." Period.

But if the patient is a well-informed, assured person who might resent taking orders, a "sharing" approach seems called for. You can explain the pros and cons of each alternative—injection, truss, or operation—and let the patient participate in the decision.

But, participation by the patient or not, the successful doctor still keeps the upper hand. As a psychiatrist, I'm convinced that a useful doctor-patient relationship can't be built on a "buddy" basis. A degree of reserve is always in order.

If the doctor tries too hard to treat the patient as friend and equal, he defeats the purpose of their relationship. This isn't a relationship of equals. It's a relationship of the sick and the well, of the frightened and the confident. You build that relationship successfully only if the patient accepts your authority. END

WHAT'S REQUIRED OF A CONSULTANT

QUESTION: *Must a consulting physician inform anyone other than the attending physician of his findings?*

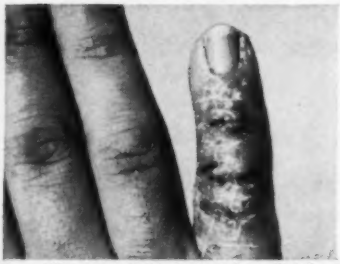
ANSWER: This is more a matter of ethics than of law. Apparently no court has yet ruled on whether the consultant is required to speak up in the presence of the patient or of some responsible relative.

But if the patient or a member of his family were to indicate in advance that they expected to be told of the consultant's findings, that would probably be considered one of the terms on which the consultant would render his service.

When there's disagreement between the attending physician and the consultant, the latter's course is clearer: "Since the consultant was employed by the patient in order that his opinion might be obtained, he should be permitted to state the result of his study of the case to the patient . . ." This quotation from a recent edition of the A.M.A. Principles of Medical Ethics is not modified by any known court decision.

—ARNOLD G. MALKAN, LL.B.

for total management of itching,[1,2] inflamed,[3,4] infected[5,6] skin lesions



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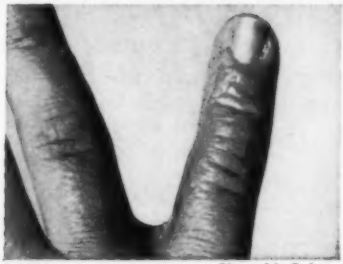

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"Thirty-one of 38 patients . . . obtained excellent or good control of dermatological lesions . . . [Mycolog] was highly effective, particularly in the management of mixed infections. Several recalcitrant eruptions which had not responded to previous therapy were remarkably responsive to the daily application of this preparation over periods of 2 to 3 weeks."[8]

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Application: Apply 2 to 3 times daily. Supply: 5 Gm. and 15 Gm. tubes. Each gram supplies 1.0 mg. (0.1 %) triamcinolone acetonide, 2.5 mg. neomycin base, 0.25 mg. gramicidin, and 100,000 units nystatin in PLASTIBASE.

References: 1. Shelmire, J. B., Jr.: Monographs on Therapy 3:164 (Nov.) 1958. • 2. Nix, T. E., Jr., and Derbes, V. J.: Monographs on Therapy 3:123 (Nov.) 1958. • 3. Robinson, R. C. V.: Bull. School of Med., U. Maryland 43:54 (July) 1958. • 4. Sternberg, T. H.:Newcomer, V. D., and Reisner, R. M.: Monographs on Therapy 3:115 (Nov.) 1958. • 5. Clark, R. F., and Hallett, J. J.: Monographs on Therapy 3:153 (Nov.) 1958. • 6. Smith, J. G., Jr.; Zawisza, R. J., and Blank, H.: Monographs on Therapy 3:111 (Nov.) 1958. • 7. Monographs on Therapy 3:137 (Nov.) 1958. • 8. Howell, C. M., Jr.: North Carolina M. J. 19:449 (Oct.) 1958. • 9. Bereston, E. S.: South, M. J. 50:547 (April) 1957.

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1. Lubowe, I. I., Am. Pract. & Digest. Treat. 7:962, 1956. 2. Niederman, M. L.: Am. Pract. & Digest. Treat. 8:1753, 1957. 3. Cornbleet, T., et al.: J. Invest. Dermat. 27:61, 1956.

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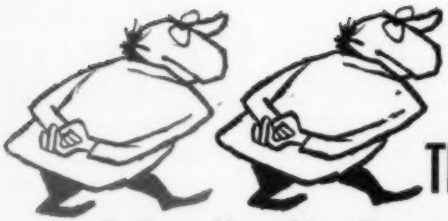

THINK TWICE Before You Give Power of Attorney!

If you fall ill or go off on a long trip, you may need to empower someone to handle your business affairs. But be wary of giving the wrong rights to the wrong party

By Irving Schultz, LL.B.

A few years ago, an Eastern doctor considered investing money in a syndicate that had apparently discovered new oil fields in Texas. So he authorized a man to go out and evaluate the syndicate and its potential. In doing so, he gave the man limited power of attorney—the power to execute contracts with the syndicate and to make investments in it.

What the physician didn't know was that his agent was already a member of the syndicate. A few days after his arrival in Texas, the fellow signed a contract requiring the doctor to put up $1,000 immediately and to invest another $9,000 later on.

As it turned out, oil never spouted in any quantity. But the contract the doctor's representative had signed was perfectly legal. The physician had to pay the full $10,000. The return on his money: nothing.

This illustrates an important point: The typical American knows too little about the risks involved in granting power of attorney to another person.

You probably have a good general idea of how such power

works. But if you take my advice —and that of all the lawyers I know—you'll make sure you fully understand the risks before you grant power of attorney to *anyone*. To see why, let's examine the exact nature of this power:

When you grant another person power of attorney, you authorize him to perform certain acts on your behalf. You're entitled to confer such power on any individual or organization you select. In most states you can confer it verbally as well as in writing.

For instance, if you tell your secretary to go downtown, buy your wife a birthday present, and charge it to your account, the girl has virtual power of attorney for this one undertaking. So if she spends $1,000 for the purchase instead of the $50 you'd contemplated, the responsibility is yours.

If you're going off on a long trip, or if you're temporarily incapacitated, it's smart to put any

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power of attorney in writing. And it's safest to have any such document drawn up by a lawyer. Reasons: There are many different kinds of power of attorney, and some are more risky than others.

Limit the Power?

Decide first between the two broad categories, general and limited:

¶ If you grant *general* power of attorney to an individual, you give him wide and sweeping powers: the right to collect your debts, to pay your bills, to sell your property, and to do a host of other things.

¶ If you grant him *limited* power of attorney, he may legally perform only such acts as you specify. For example, if you give your aide the right to sign your business checks, you've given her limited power of attorney.

You may be taking chances even when you grant only limited power to another person. (A secretary who has the legal right to sign your checks can obviously abuse that right.) But you're really sticking your neck out when you confer general power of attorney.

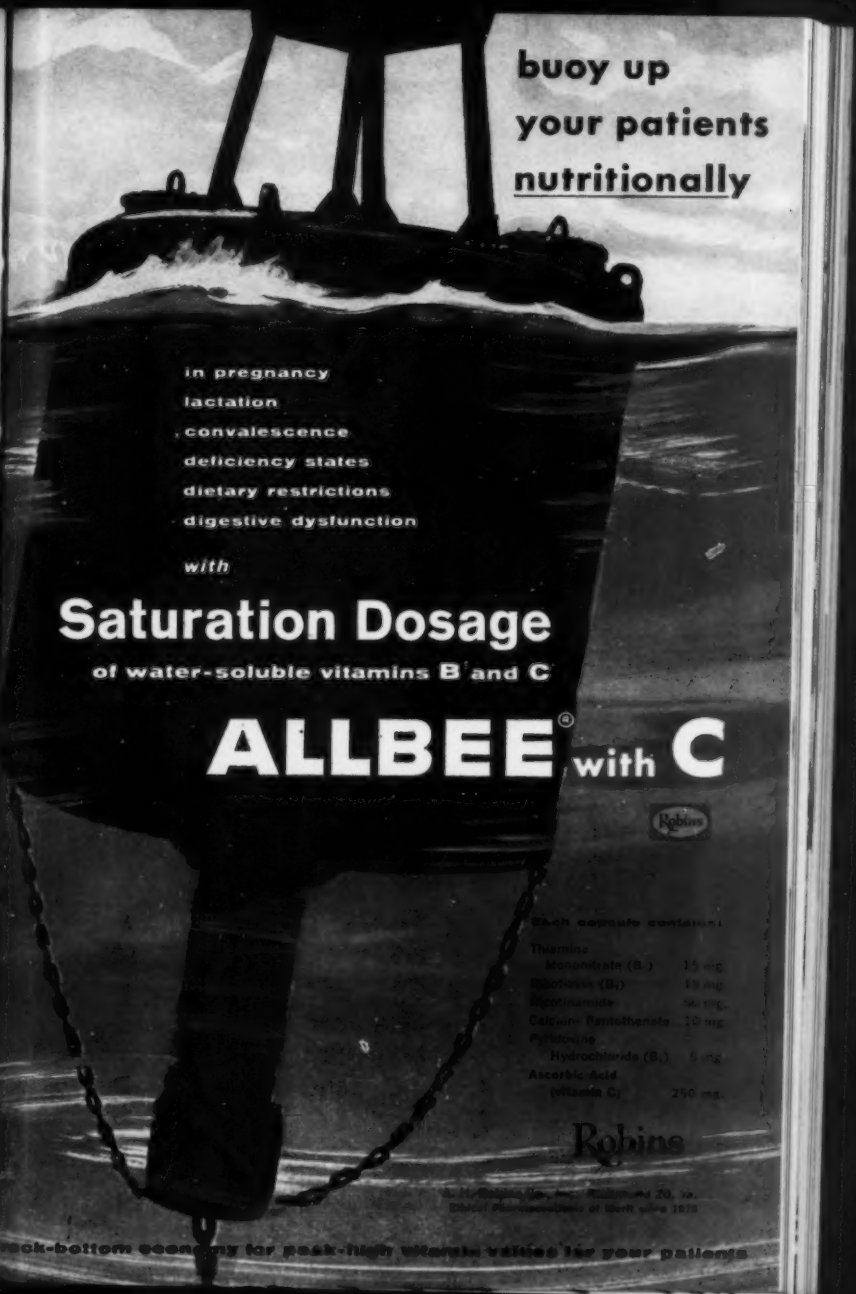
One lawyer I know tells about a young man who asked him to draw up an irrevocable contract granting him general power of attorney over the affairs of his elderly mother. The woman was perfectly willing to rid herself of the burden of managing her affairs. She gladly signed the agreement.

It was a serious mistake. Her son sold her property. He had her stocks made over to him. He withdrew her entire bank account and deposited it in his own. He and his mother soon quarreled. But because she'd granted him irrevocable power of attorney, there wasn't a thing she could do without going through a great deal of red tape to prove fraud.

Usually It's Temporary

Fortunately, that's an extreme case. Most people don't grant irrevocable power of attorney. Instead, they retain the legal right to withdraw such power at any time.

Even so, damage may be done before the power is revoked. If the person upon whom you've conferred it does something illegal, he'll probably be held responsible for his error. But there are circumstances under which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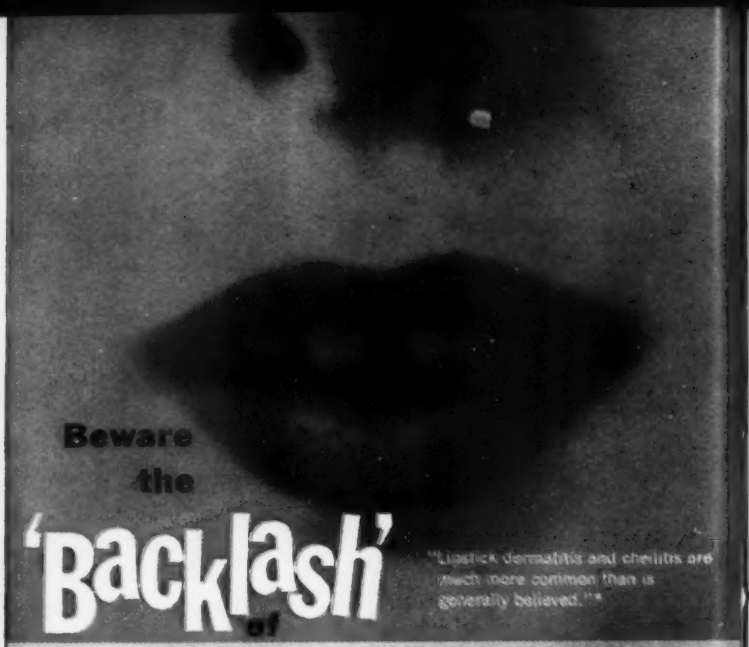

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*Zakon, S. J., et al.: Arch. Dermat. & Syph. 56:499, 1947; abstracted in Birmingham, D. J., and Campbell, P. C., Jr.: Occupational and Related Dermatoses, U. S. Public Health Service Publication No. 364, 1954.

you might have to share his responsibility—for instance, if you're found guilty of negligence of one kind or another.

And remember this: Even though your attorney-in-fact (as he's called) never violates his trust, the course of action he pursues may differ radically from the one you'd have taken. Friendships have been broken because the person who'd granted power of attorney didn't like the decisions his attorney-in-fact had taken on his behalf.

So here's my recommendation:

Don't grant any individual the sweeping rights conferred by a *general* power of attorney. And think twice before conferring *limited* power. If you decide to go ahead, spell out exactly what rights you're conferring. Either check your contract with a lawyer, or—better still—have him draw it up in the first place.

If you do decide to confer such power, your best bet may be to grant it to a bank or trust company rather than to an individual. Such institutions charge reasonable fees for their services. They bond their employes. And they're less likely to make bad mistakes. END

Nice catch

In my husband's rural practice, patients who phone him give as little information as possible because of the other ten people on the party line. One evening we were finishing dinner, with our 6-year-old at the table and our 2-week-old baby in the bassinet nearby. The phone rang. I answered it and then gave the message to the doctor: "That was Mr. Kline. He's bringing his wife in. He thinks she's going to have what we just had."

Whereupon our 6-year-old asked: "What'd he mean, Ma —fish?"

—FAE BERTOLETTE

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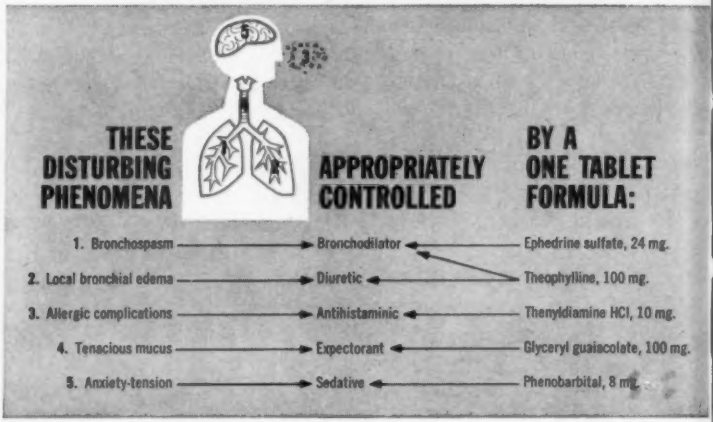

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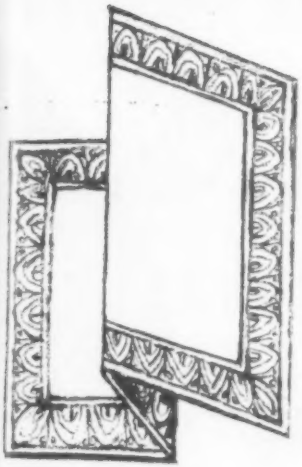
1. Personal communication. 2. Foland, J. P.: Postgrad. Med. 18:397 (Nov.) 1955.



NOW YOU CAN INSURE YOUR INSURABILITY

For a small extra premium, a number of life insurance companies are guaranteeing their policyholders the right to buy much more coverage later on. Here's the story

By Arnold Geier

Nearly 200,000 people couldn't get life insurance last year because of physical impairments. Many of them were men who already had some coverage but who found it impossible to buy the additional policies they needed in order to have adequate protection.

"When I was younger, I didn't need too much life insurance, nor could I afford it," one doctor told me recently. "Today, when I'm ready for more, I discover that I'm uninsurable. That's quite a blow."

It's too late for him to do anything about it. But if you're still young and healthy, there's now a good way for you to insure your future insurability, if you want to.

And if you're an older doctor, you can do the same sort of thing

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THE AUTHOR *is an independent insurance underwriter in Miami, Fla.*

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Adequate intake of Knox Gelatine (min. 1 envelope —7 Gm. or 120 grains per day) is absolutely essential to produce the Specific Dynamic Action necessary to correct the brittle nail defect. If you would like to examine at first hand the clinical research establishing this use of Knox Gelatine, just use the coupon below.

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- ☐ 2. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therapy 4:403, July 1957.
- ☐ 3. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March 1955.
- ☐ 4. Tyson, T.L.: J. Invest. Dermat. 14:323, May 1950.

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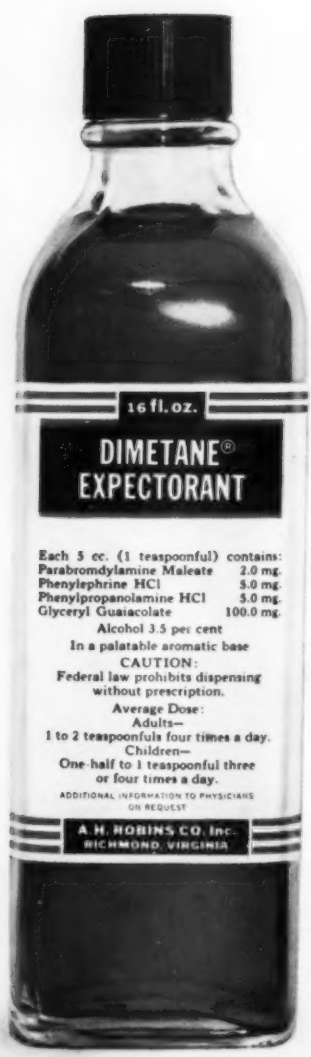
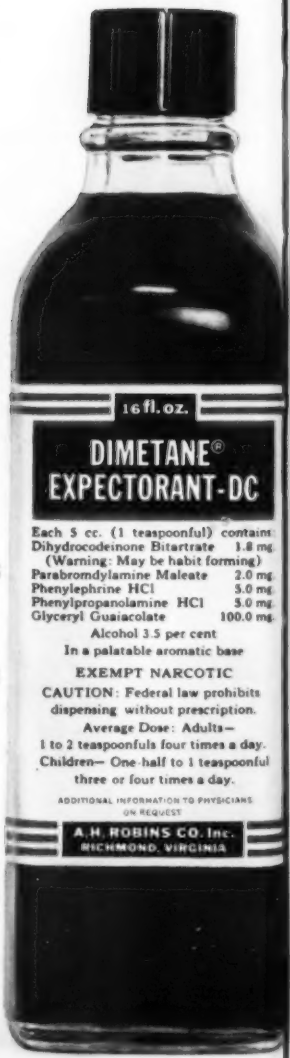


read the labels on these delicious new cough products to see why they work better.



for your children. For example, you can buy your son a $10,000 policy that will guarantee him the right to another $60,000 of coverage later on, *regardless of his occupation then or the state of his health.*

The Trouble With Term

This is a really modern life insurance concept. The only answer to the problem of future insurability used to be term insurance. And one trouble with term coverage is that you may have to buy a lot more of it than you currently need, in order to make sure you'll have enough protection on some future conversion date.

By contrast, the new plan permits you simply to buy the *right* to purchase more insurance later on. Here's how such a plan works:

For a small additional premium (an average of $1.50 a year per $1,000), the company guarantees you the right to buy extra coverage equal to your original amount (but not to exceed $10,000). You can exercise this right several times—when you reach ages 25, 28, 31, 34, 37,

and 40. If you do exercise the right, you can get any type of permanent coverage you want. And you can get it without evidence of insurability.

$50,000 in Ten Years

For example, if you're now 30 years old and if you purchase a $10,000 policy with the "guaranteed insurability option," you'll be able to buy another $10,000 policy four more times, at ages 31, 34, 37, and 40. Thus, your original purchase assures you of a total of $50,000 of coverage by the time you reach 40. No matter how your health may deteriorate between now and then, the company can't reject your applications for the extra policies.

For Your Children Too

So if you're still young, you may find this a dependable way to start your insurance program rolling. And if you're not young enough to take advantage of the new plan, consider its possibilities for your children.

No man can predict his son's future occupation. In this atomic era, it's always possible that your boy may take up a hazardous profession that will deny him the right to buy life insurance even if his health is perfect. So you may be doing him a service if you guarantee him eventual access to $70,000 of coverage by buying him a $10,000 policy today.

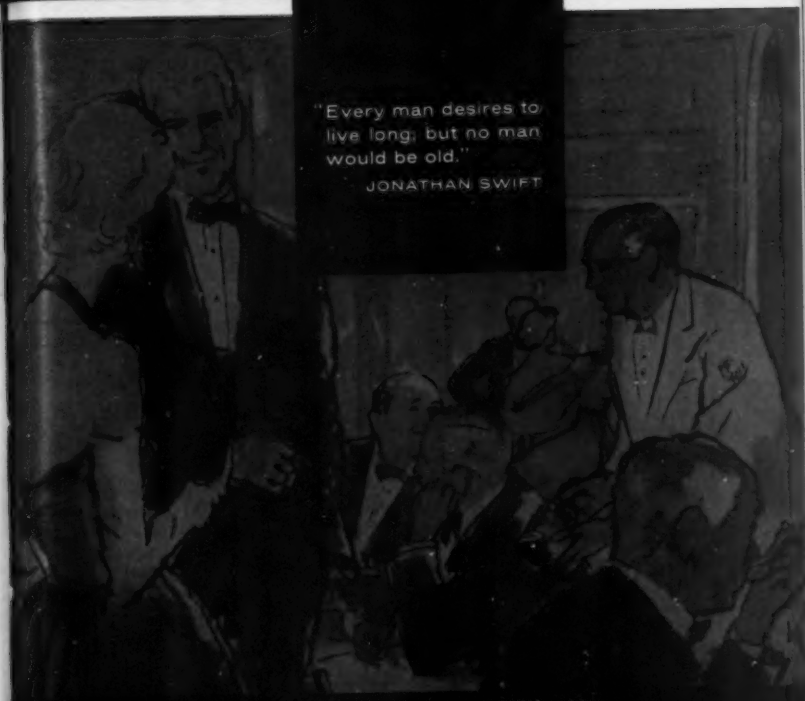
As of now, only a limited number of companies offer the guaranteed insurability option. But it seems likely that many others will soon be doing so.

Who Sells It Now?

Meanwhile, here's a list of some of the concerns that already offer this option:

American United
Bankers of Iowa
Bankers National
Connecticut General
Equitable Society of New York
General American
Guarantee Mutual
Jefferson National
John Hancock
Life of North America
Lincoln National
The Maccabees
Maine Fidelity
Manufacturers
Mutual of New York
National Fidelity
New York Life
North American Assurance
Penn Mutual
Provident of Tennessee
State Mutual
Union Mutual

END



help prepare your patients
for a healthy, active later life

PRESCRIBE

ELDEC

vitamin-mineral-hormone supplement

KAPSEALS®

during their middle years

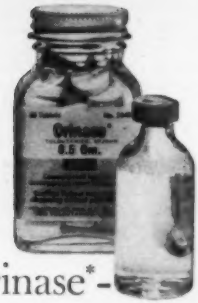
each KAPSEAL *contains:*

vitamins	
Vitamin A	1,667 Units (0.5 mg.)
Vitamin B_1 mononitrate	0.67 mg.
Ascorbic acid	33.3 mg.
Nicotinamide	16.7 mg.
Vitamin B_2	0.67 mg.
Vitamin B_6	0.5 mg.
Vitamin B_{12} with intrinsic factor concentrate	0.033 USP Unit (oral)
Folic acid	0.1 mg.
Choline bitartrate	6.67 mg.
Pantothenic acid (as the sodium salt)	5 mg.
minerals	
Ferrous sulfate (exsiccated)	16.7 mg.
Iodine (as potassium iodide)	0.05 mg.
Calcium carbonate	66.7 mg.
digestive enzymes	
Taka-Diastase®	20 mg.
Pancreatin	133.3 mg.
protein improvement factors	
l-Lysine monohydrochloride	66.7 mg.
dl-Methionine	16.7 mg.
gonadal hormones	
Methyl testosterone	1.67 mg.
Theelin	0.167 mg.

dosage: One Kapseal three times daily before meals. Female patients should follow each 21-day course with a 7-day rest interval.

packaging: ELDEC Kapseals are available in bottles of 100.

PARKE, DAVIS & COMPANY Detroit 32, Michigan



Combined Orinase*-insulin therapy enables you to "stabilize" a surprising percentage of "brittle" diabetics

The primary indication for Orinase remains in the stable, maturity-onset diabetic in whom Orinase usually can fully replace insulin therapy. But now a further indication has developed from the cumulative data of the past several years: many labile diabetics, who cannot be managed on Orinase alone, can benefit from the *addition* of Orinase to their insulin regimen.

A major benefit—stabilization

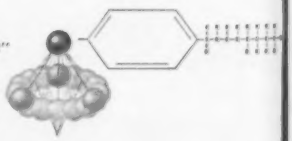
In the labile diabetic who successfully responds to joint insulin-Orinase management, the "peaks and valleys" of erratic blood sugar levels are rarely observed. The addition of Orinase greatly reduces sudden and unexpected changes . . . tends to "stabilize" even the "brittle" diabetic.

A major benefit—lessened insulin needs

The Orinase-stabilized labile diabetic generally requires less insulin than before the inclusion of Orinase in his regimen. This lessening of insulin dosage is particularly advantageous in the patient who is insulin-dependent, but who reacts unfavorably —whether by lipodystrophy or otherwise—to insulin.

The derived benefits—less hypoglycemia, less anxiety, greater well-being

With stabilization, the hazards of shock or coma are diminished. Like the diabetic who is responsive to Orinase alone, the labile diabetic on combined therapy need no longer walk a slender tightrope between hypo- and hyperglycemia. The patient's fears are greatly lessened . . . often to be replaced by the healthier outlook characteristic of *euglycemic* Orinase management. *TRADEMARK, REG. U. S. PAT. OFF.—TOLBUTAMIDE, UPJOHN



Upjohn

The Upjohn Company
Kalamazoo, Michigan

Put Money Into Real Estate Syndicates?

You probably know they're a relatively new way for small investors to get big returns. Read this article, and you'll know a lot more

By Melrick Landen

Want to own a piece of the General Motors building in New York, of the Corn Products building in Chicago, or of the Senator Hotel in Sacramento?

That isn't a silly-season question. Though such top-grade real estate investments used to be beyond the reach of most doctors, they no longer are. You can buy into any one of those three properties, as well as into thousands of other U.S. hotels, office buildings, shopping centers, and apartment houses. How to do it? Through real estate syndicates.

Simply stated, a real estate syndicate is a group of people who have pooled their money to invest in income-producing property. That's not a new idea for big investors. But only within the last half-dozen years have the doors been opened to the small investor. And they've been opened wide.

You can now put as little as $5,000—often even less—into a real estate syndicate. And more and more investors are doing just that. An estimated $9,000,000,000 worth of real estate is already owned by the syndicates. The total is rising at a rate of about $3,000,000,000 a year.

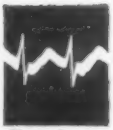
The syndicates' big attraction

THE AUTHOR *is a real estate investment adviser in New York City.*

"nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

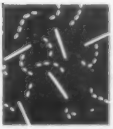
the rationale fo

in cardiac disease



"B vitamins should be an integral part of the treatment prescribed for any patient with cardiac disease.... As a consequence of special low salt diets and diuretics prescribed to release the water held in the body fluids by an excess of sodium, the B vitamins are 'washed out' of the body with the salt, and the difficulties of the disease are compounded."[2]

in infectious disease



"There are ample, critical, statistically significant studies to indicate that good nutrition is important for optimal resistance to infection, for a superior tissue capability to cope with disease and injury, and for maximum antibody formation."[3]

"Fever also increases vitamin requirements. This is especially true of B-complex and C vitamins. Liquid and soft diets, which are commonly prescribed early in disease, are inadequate in these vitamins. It is advisable to give supplementary vitamin capsules during the actual illness and convalescence."[3]

Each Theragran *supplies:*

Vitamin A	25,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Thiamine Mononitrate	10 mg.
Riboflavin	10 mg.
Niacinamide	100 mg.
Ascorbic Acid	200 mg.
Pyridoxine Hydrochloride	5 mg.
Calcium Pantothenate	20 mg.
Vitamin B_{12} Activity Concentrate	5 mcg.

Dosage: 1 or more daily as indicated.

Supply: Family Packs of 180. Bottles of 30, 60, 100 and 1,000.

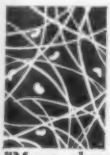
THERAGRAN with Minerals available as THERAGRAN-M
(SQUIBB VITAMIN MINERALS FOR THERAPY)
bottles of 30, 60, 100 and 1,000 capsule-shaped tablets and Family Packs of 180.

Also available: **Theragran Liquid, bottles of 4 ounces; Theragran Junior, bottles of 30 and 100.**

References: 1. Youmans, J. B.: *Am. J. Med.* 25:659, Nov. 1958. 2. Gertler, M. M.: Paper presented at Conference on Metabolic Factors in Cardiac Contractility, N. Y. Acad. Sciences, New York City, N. Y., March 18-19, 1958. 3. Fernandy-Herlihy, L.: *Lahey Clinic Bull.* 11:12, July-Sept. 1958. 4. Spies, T. D.: *J.A.M.A.* 167:675, June 7, 1958. 5. Halpern, S. L.: *Ann. N. Y. Acad. Sci.* 5:147, Oct. 28, 1955. 6. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 54. 7. Kountz, W. B.: *Mod. Med.* 25:102, Aug. 1, 1957. 8. Sebrell, W. H.: *Am. J. Med.* 25:673, Nov. 1958.

The use of vitamins

in rheumatoid arthritis



"It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis [collagen disease] simply to insure nutritional adequacy..."[3]

"Many rheumatologists now look for nutritive failure among the patients who have arthritis and other debilitating diseases."[4]

in degenerative disease

"Most degenerative disease changes are believed to be related to disturbed nutrition....Even though blood levels may be adequate [for vitamin A, vitamin D, thiamine, ascorbic acid, and riboflavin]....many individuals will improve with supplementary administration."[7]

"In chronic diseases...in which there is a loss of appetite, difficulty in eating or abnormal metabolic demand, symptoms of B vitamin deficiencies also have been found frequently and should always be looked for in their management."[8]

for the next patient you see who needs nutritional support

Theragran

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'Theragran'® is a Squibb trademark.

is their current rate of return: about 8 to 12 per cent, sometimes even more. That's far better than any dividend you're likely to get on a common stock. In addition, real estate holdings offer certain tax benefits that other kinds of investment can't match.

So it's no wonder that a good many doctors are putting money in the syndicates these days. It's hard to resist the lure of high returns from real estate with none of the management headaches that usually go with it. But before *you* join the parade, remember this:

The yield of any investment is directly proportional to the risk. Real estate syndicates are no exception to the rule.

How One Syndicate Works

To see just how they operate, and to understand the potential pitfalls, let's take a closer look at one of them. It's a real syndicate, but I won't identify it. I'll simply call the property it owns the Chestnut County Shopping Center.

A year or so ago, when the shopping center was priced at $1,000,000, a real estate promoter whom I'll call Jones formed a limited partnership to buy it. The partnership shelled out $300,000 in cash, with a 5½ per cent mortgage covering the rest of the purchase price. Then the equity was split into thirty-six units priced at $10,000 each.

Dr. Brown and thirty-two other investors bought a unit each, thus putting a total of $330,000 into the Chestnut County syndicate. Mr. Jones got the other three units without charge as his fee for arranging the deal and managing the center.

Of the money collected, $30,000 went into working capital for the center. The other $300,000 provided the needed equity.

First Year's Income

At the end of the first year, the syndicate's income statement showed these figures:

Gross income	$170,000
Less operating expenses	80,000
Less interest on mortgage	38,500
Net income	$ 51,500
Less mortgage reduction	21,000
Income for distribution	$ 30,500

Each of the thirty-six units was credited with a proportionate share of the income available for distribution. As the owner of

dieting is

TORTURE

The patient complains: "This diet is killing me! I can't keep my mind off food! Maybe I should just give up and eat what I please because DIETING IS TORTURE!"

for the patient who can't stay on a diet prescribe the diet but add

Obocell®-TF

Obocell-TF (tension formula) contains an antidisturbant, methapyrilene, to help the obese patient endure a strict diet. Methapyrilene is not a barbiturate . . . does not produce barbiturate side effects. Obocell-TF combines this antidisturbant with *d*-amphetamine phosphate to curb the appetite and provide a "controlled lift," eliminating possible CNS overstimulation. At the same time Obocell-TF controls bulk hunger with Nicel. And Obocell-TF can be given in the evening to combat the night-eating syndrome without disturbing sleep.

Each Obocell-TF tablet contains:

Methapyrilene, an antidisturbant	25 mg.
d-amphetamine phosphate (dibasic) ..	5 mg.
Nicel, non-nutritive, hydrophilic agent.	150 mg.

For Rx economy prescribe Obocell-TF in 100's.

Neisler

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Decatur, Illinois

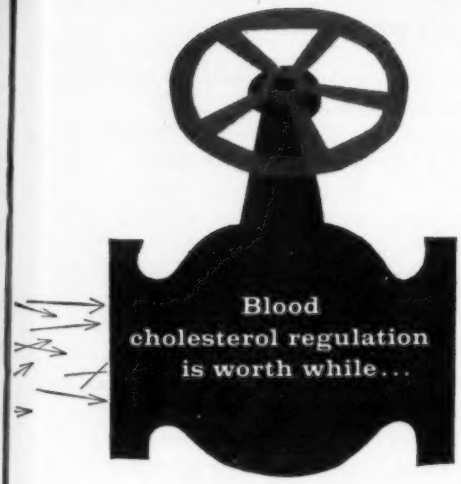
one unit, Dr. Brown got $847—nearly 8½ per cent on his original $10,000 investment. Not bad at all. And when you dig a little deeper, it looks even better.

As shown in the income statement, part of the shopping center's net income goes to reduce the mortgage. Although this portion of the money isn't distributed to the syndicate members, it increases their equity in the property. Dr. Brown's share of the amortization for last year was $583. So the total one-year return on his investment was actually $1,430.

Now income taxes enter the picture. The entire $1,430 is taxable income, even though Dr. Brown got only $847 of it in cash. But tax deductions offset quite a bit of the tax cost. That's because of the shopping center's depreciation deduction.

The depreciation for the shopping center's first year would reasonably amount to about $40,000. As part owner of the property, the doctor can claim his proportionate share of this—about $1,111. So he has to pay taxes on only $319 ($1,430 minus $1,111). This despite the fact that he got a cash distribution of $847.

More▶



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*Amsterdam, B.: New York J. Med. *58*:2199-2212 (July 1) 1958. Panel Discussion on Proper Nutrition for the Older Age Group, J. Am. Geriatrics Soc. *6*:787-802 (Nov.) 1958. Leckert, J. T.; Donovan, C. B.; McHardy, G., and Cradic, H. E.: J. Louisiana M. Soc. *110*:260-266 (Aug.) 1958.

Each tablespoonful (15 ml.) of Arcofac contains:

Essential fatty acids†. . . 6.8 Gm. (measured as linoleic) with 2.5 I.U. of Vitamin E††

Pyridoxine hydrochloride (Vitamin B_6). . . . . 1.0 mg.

†Supplied by safflower oil which contains the highest concentration of polyunsaturated fatty acids of any commercially available vegetable oil.

††Added as Mixed Tocopherols Concentrate, N. F.

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Obviously, Dr. Brown has reason to be pleased at the end of the first year. What happens after ten or twenty years may be another story. The doctor's investment *may* prove even more profitable. But it may also prove increasingly disappointing. Some developments that could cut the rate of return:

What Could Go Wrong

¶ A new shopping center may open up down the road. It may cut deeply into Chestnut County's rental income.

¶ Apex Supermarket, one of Chestnut County's big renters, may decide to pull out when its lease expires. The space may remain vacant for a long time.

¶ Business at the center may not come up to expectations. In this event, the renters may demand—and may get—rent reductions.

¶ Declining real estate values in the county may pull the value of the shopping center down.

¶ As the buildings grow older, their value may drop. Maintenance and operating expenses may increase. Major renovations may be needed.

¶ Dr. Brown may want to sell his interest at a time when no one will buy it—at least not for the price he paid.

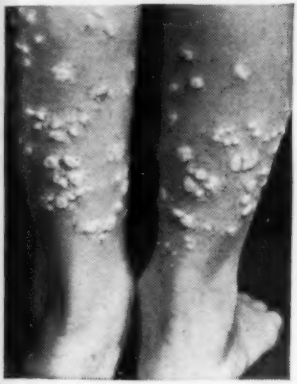
Then, too, the tax benefits decrease when the property ages. As the mortgage is paid off, the deduction for interest grows steadily smaller. After the buildings have been fully depreciated, there's no longer any depreciation deduction.

On the other hand, as I've said, the investment may pay off even better than you'd expect. Business may boom; the center may stay fully occupied; rents may go up; buyers may offer Dr. Brown far more than $10,000 for his share in the syndicate.

It May Appreciate

The value of property doesn't necessarily decline with age. Many parcels of commercial property are worth much more today than they were twenty years ago. And if the building is sold, the profits are taxed at the favorable long-term capital gains rate.

The point is, a syndicate investment isn't tantamount to buying a mortgage. The rate of return is *not* guaranteed; neither is the value of your share. As a syndicate member, you're a part owner of the property. So you



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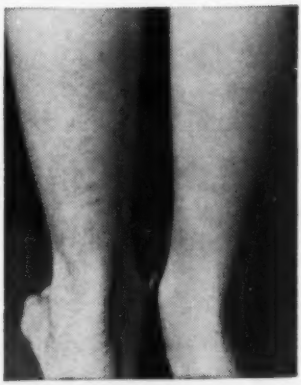

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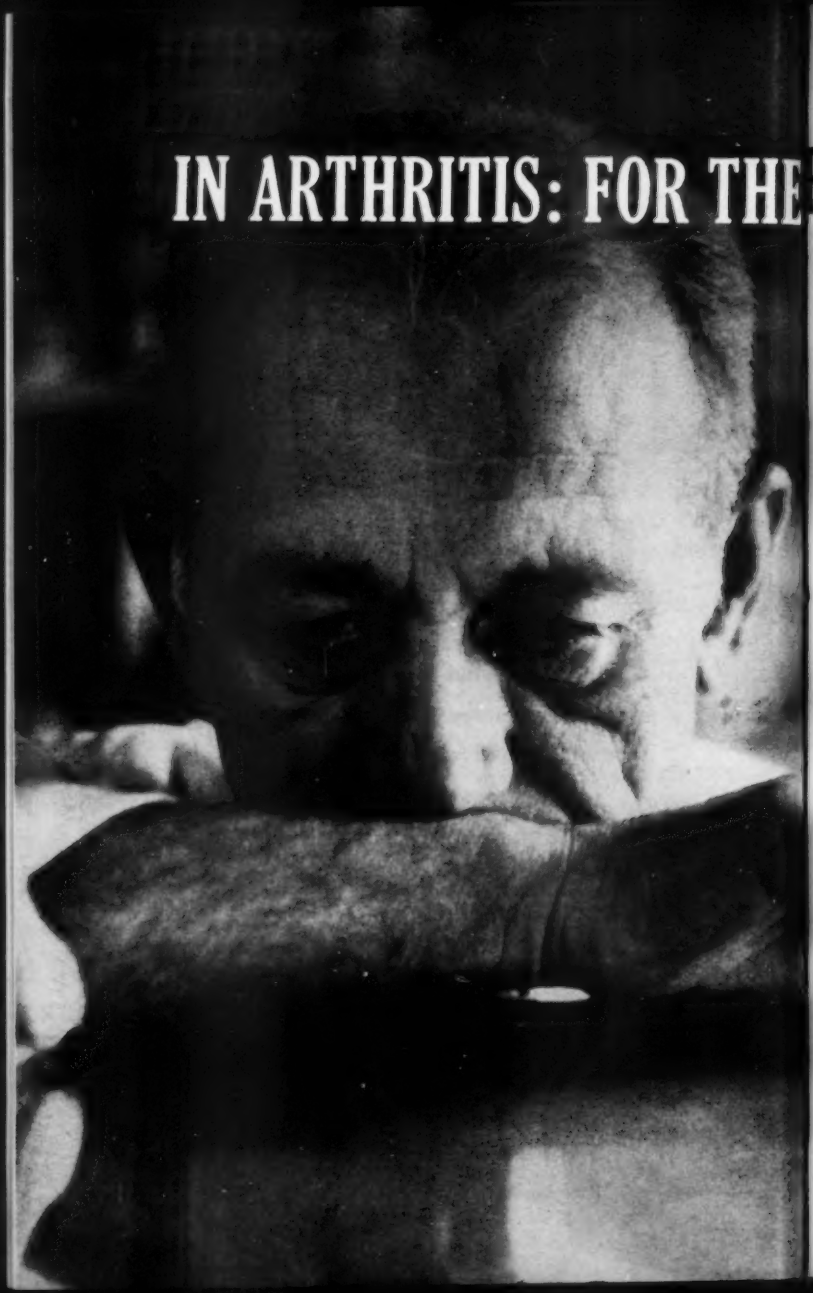
IN ARTHRITIS: FOR THE

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Supplied: **ATARAXOID *5.0*** – scored green tablets, 5.0 mg. prednisolone and 10 mg. hydroxyzine hydrochloride, bottles of 30 and 100. **ATARAXOID *2.5*** – scored blue tablets, 2.5 mg. prednisolone and 10 mg. hydroxyzine hydrochloride, bottles of 30 and 100. **ATARAXOID *1.0*** – scored orchid tablets, 1.0 mg. prednisolone and 10 mg. hydroxyzine hydrochloride, bottles of 100.

1. Hutcheon, D. E., et al.: Paper presented at Am. Soc. Pharmacol. & Exper. Therap., Nov. 8-10, 1956, French Lick, Ind. 2. Johnston, T. G., and Cazort, A. G.: Clin. Rev. 1:17, 1958. 3. Warter, P. J.: J. M. Soc. New Jersey 54:7, 1957. 4. Individual Case Reports to Medical Dept., Pfizer Laboratories. 5. Strub, I. H.: To be published.

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share in all its fortunes, both good and bad.

That's why you should study any such proposition—*and the men who are promoting it*—as thoroughly as if you were buying the property on your own.

How do you evaluate the prospects of a given syndicate? Well, above all, you find out whether it has been organized by experienced real estate men who aren't likely to sponsor potential duds. Such promoters don't usually sell the entire property to investors. They stay on as participants, retaining shares in the organization and serving as its managers.

Their continued participation offers obvious advantages. It binds experienced professionals to the syndicate and relieves other investors of supervisory responsibilities. It may also help pave the way toward bigger earnings.

"We're always thinking of how rents can be increased and expenses cut," says a Washington syndicate manager. "We often do a major overhaul job—perhaps by remodeling or by installing air conditioning or new elevators."

Unfortunately, it isn't always easy to get full information about a real estate syndicate. Some of the larger ones operate in more than one state. They must file with the Securities and Exchange Commission and must issue a prospectus. But most syndicate deals are relatively small.

When they're promoted by a

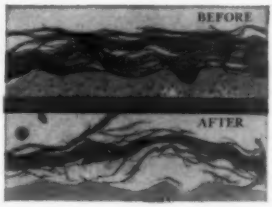
THE HUSBAND HAS TO PAY YOU

QUESTION: *Can a physician collect for services to a woman who has employed him against her husband's wishes?*

ANSWER: As a rule, yes. A husband is legally required to provide his wife with medical services. He may escape liability, however, if (a) he is willing to provide his wife with the services of some other doctor; or (b) the wife tells the doctor she is able to pay and requests that she alone be billed; or (c) the husband provides separate maintenance. —ARNOLD G. MALKAN, LL.B.

New freedom from embarrassment and distress of psoriasis!

Alphosyl T.M. LOTION



DISAGGREGATES PSORIATIC SCALE

In vitro studies show that the keratin-dispersing action of allantoin is exceptionally effective in disaggregating psoriatic scale.[1,2] It apparently acts on an abnormal cement substance between cornified cells.[2,3] Coal tar, too, helps break up the horny layer.[2] Together, these agents provide rapid clearing of psoriatic lesions as well as the underlying inflammation and erythema.

ALPHOSYL Lotion, used by many physicians both in routine practice and in carefully controlled studies, proved highly successful.[2,4-7] The lotion permits complete avoidance of the potential hazards of certain other methods of treatment, such as superficial x-ray, heavy metals and corticosteroids.[7]

Advantages: • Treatment-fastness not observed • Cosmetic qualities permit free application to the scalp • Notably safe • May be freely used on tender areas

FORMULA: Allantoin 2% and special coal tar extract 5% in a greaseless, stainless, vanishing lotion base.

SUPPLIED: Bottles of 8 fl. oz.

APPLICATION: For maximum therapeutic results rub thoroughly into lesions 2 to 4 times daily. For maintenance apply once or twice a week.

REFERENCES: 1. Flesch, P.: Proceedings Scientific Session. Toilet Goods Assoc. June, 1958. 2. Samitz, M. H.: Ann. New York Acad. Sc. 73:1020, 1958. 3. Flesch, P., and Jackson Esoda, E. C.: Ann. New York Acad. Sc. 73:989, 1958. 4. Bleiberg, J., and Saltzman, J. A.: Clin. Med. 5:485, 1958. 5. Bleiberg, J.: Ann. New York Acad. Sc.: 73:1028, 1958. 6. Clyman, S. G.: Ann. New York Acad. Sc. 73:1032, 1958. 7. Welsh, A. L., and Ede, M.: Ohio M. J.: to be published.

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local realty man or attorney for the purchase of near-by property, they're not obliged to meet S.E.C. disclosure requirements; they're not required to put out the full facts.

Buying without the full facts can mean a big extra risk for the investor. Properties have been known to be syndicated simply because the owner couldn't unload them in any other way. And some promoters have been less than candid when pressed for details on operating expenses, tax credits, etc.

Not long ago, a reporter for the Wall Street Journal walked into the office of one such promoter. Acting the part of an amateur investor, the reporter inquired about investment possibilities.

"The conversation ends," the reporter later wrote, "when the visitor insists he be shown a prospectus of the syndicator's offering . . . When the prospectus is reluctantly produced, it discloses such enlightening facts as the following: . . . The most recent earnings statement showed that 20 per cent of the company's gross income was spent for 'general expenses,' compared with management fees of about 3 per cent for firms specializing in operating [similar] properties."

Even worse abuses than that have come to light. Last year, New York's Attorney General brought four syndicate operators into court on charges of bilking 1,200 investors of up to $5,000,000. One of these promoters had collected $500,000 from investors. Yet he had exactly 2 cents in his bank account.

Such shenanigans are by no means typical. I mention them only to emphasize this warning: In syndicates, as in most other types of investment, the buyer must be wary.

You may be impressed with a newspaper ad for a given syndicate. Or you may get a tempting offer by mail or phone. You may even ask a well-established real estate man for the names of some local organizations. But before you put your money in any syndicate, you'll do well to take the following precautions:

How to Protect Yourself

1. Be sure you get a prospectus that outlines all details of the deal, including such matters as the promoter's compensation and management charges. It's

when pollen allergens attack the nose...

Triaminic provides more effective therapy in respiratory allergies because it combines two antihistamines[1,2] with a decongestant.

These antihistamines block the effect of histamine on the nasal and paranasal capillaries, preventing dilation and exudation.[3] *This is not enough;* by the time the physician is called on to provide relief, histamine damage is usually present and should be counteracted.

The decongestive action of orally active phenylpropanolamine helps contract the engorged capillaries, reducing congestion and bringing prompt relief from nasal stuffiness, rhinorrhea, sneezing and sinusitis.[4,5]

TRIAMINIC is orally administered, systemically distributed and reaches *all* respiratory membranes, avoiding nose drop addiction and rebound congestion.[6,7] TRIAMINIC can be prescribed for prompt relief in summer allergies, including hay fever.

References: 1. Sheldon, J. M.: Postgrad. Med. 14:465 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: Annals Allergy p. 350 (May-June) 1950. 3. Kline, B. S.: J. Allergy 19:19 (Jan.) 1948. 4. Goodman, L. S. and Gilman, A.: Pharmacol. Basis Ther., Macmillan, New York, 1956, p. 532. 5. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 6. Lhotka, F. M.: Illinois M.J. 112:259 (Dec.) 1957. 7. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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TRIAMINIC provides around-the-clock freedom from hay fever and other allergic respiratory symptoms with just one tablet q. 6-8 h. because of the special timed-release design.

Each TRIAMINIC timed-release tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Also available: TRIAMINIC SYRUP for those patients of all ages who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ Triaminic Tablet or ½ Triaminic Juvelet. TRIAMINIC JUVELETS provide half the dosage of the Triaminic Tablet with the same timed-release action for prompt and prolonged relief.

STOP *running noses* *and open stuffed noses orally*

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- has been reported to be effective even in patients who do not respond satisfactorily to other diuretics
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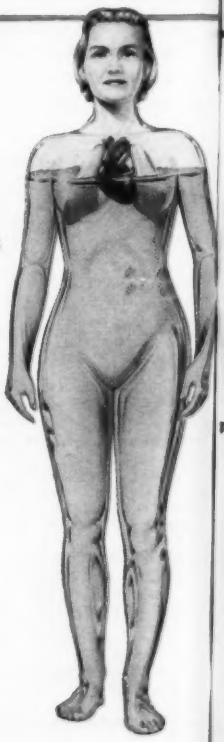
- often achieves the benefits of a low salt diet without the unpleasant restriction



Indications: Hypertension, congestive heart failure of all degrees of severity, premenstrual syndrome (edema), edema and toxemia of pregnancy, renal edema—nephrosis, nephritis; cirrhosis with ascites, drug-induced edema, and as adjunctive therapy in the management of obesity complicated by edema.

dosage: In edema—one or two 50 mg. tablets of HYDRODIURIL once or twice a day.

In hypertension—one or two 25 mg. tablets or one 50 mg. tablet HYDRODIURIL once or twice a day.

supplied: 25 mg. and 50 mg. scored tablets HYDRODIURIL (Hydrochlorothiazide) in bottles of 100 and 1,000.

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Additional information on HYDRODIURIL is available to the physician on request.

bibliography: 1. Esch, A. F., Wilson, I. M. and Freis, E. D.: 3,4-Dihydrochlorothiazide: Clinical Evaluation of a New Saluretic Agent. Preliminary Report; M. Ann. District of Columbia **28**:9, (Jan.) 1959. 2. Ford, R. V.: The Clinical Pharmacology of Hydrochlorothiazide; Southern Med. J.**52**:40, (Jan.) 1959. 3. Fuchs, M., Bodi, T., Irie, S. and Moyer, J. H.: Preliminary Evaluation of Hydrochlorothiazide ('HYDRODIURIL'); M. Rec. & Ann. **51**:872, (Dec.) 1958. 4. Moyer, J. H., Fuchs, M., Irie, S. and Bodi, T.: Some Observations on the Pharmacology of Hydrochlorothiazide; Am. J. Cardiol. **3**:113, (Jan.) 1959.

HYDRODIURIL (HYDROCHLOROTHIAZIDE)

- highly-active derivative of chlorothiazide
- qualitatively similar to DIURIL* but at least 10 to 12 times more potent by weight
- loss of potassium is clinically insignificant in the great majority of patients on normal diets

HYDRODIURIL*

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IN HYPERTENSION:

- effective by itself in some patients—markedly potentiates other antihypertensive agents
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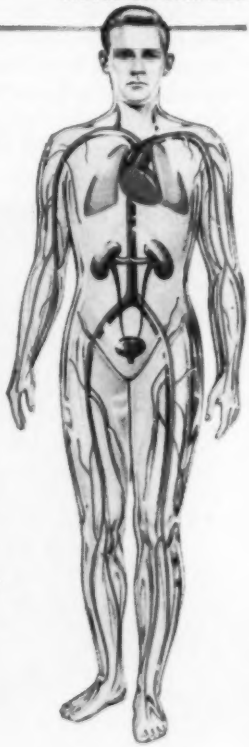

Precautions: It is important that the dosage be adjusted as frequently as the needs of the individual patient demand. When HYDRODIURIL is used with a ganglion blocking agent, it is mandatory to reduce the dose of the latter by at least 50 per cent, immediately upon adding HYDRODIURIL to the regimen.

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The excretion of potassium is much lower than that of sodium or chloride and, as is the case with DIURIL®, the loss of potassium is clinically insignificant in the great majority of patients on normal diets. If indicated, potassium loss may easily be replaced by including potassium-rich foods in the diet (orange juice, bananas, etc.).

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often hard to analyze this sort of material. So don't hesitate to ask an investment adviser to review it with you.

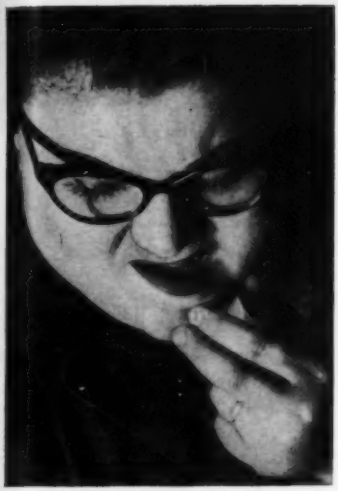
2. Find out how long the mortgage has to run, the length of the tenants' leases, and the major repairs and renovations coming up. Consider the impact of such things on your potential profits.

3. Make sure the promoter has some of his own money invested in the syndicate. That's the only way to be certain of his continued services and interest.

4. Check on the reputation and experience of the promoter. What's his real estate background? Has he ever syndicated other properties? If so, how are they doing?

5. Ask yourself whether you can afford to part with your money for a relatively long period. You can't jump in and out of real estate as easily as you can buy and sell stocks.

6. Bear in mind that all prognoses of the property's earnings and expenses are only estimates. In other words, prepare yourself psychologically for the risks as well as the rewards. END



Overweight

Mrs. Geller rebelled at the monotony of housekeeping chores and the antics of her school-age children added tension to boredom. Eating became an outlet for her emotions. A daily

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an artful balance of 10 mg. methamphetamine hydrochloride and 1 gr. phenobarbital, not only curbed her appetite, but by aiding in a renewal of creative interests, tempered her reactions to minor irritations.

weight reduced, mood relieved with Ambar™

Obesity

and Mrs. Adams seem inseparable. She has tried all the current diet fads her friends, relatives and the newspapers tell her to try, and she says they don't work. She knows how unrelenting are the frustrations that drive her to overeating. She can use the more potent dose of the 15 mg. methamphetamine hydrochloride with 1 gr. phenobarbital in

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CAN THEY CLAIM YOU 'ABANDONED' THE BABY?

When you handle an OB case, the newborn child is your responsibility unless another doctor actually takes over. Here's what the law says

BY JOHN R. LINDSEY

"A colleague said to me the other day, 'No law in the world can make you accept a patient you don't want.' Sounds good, but is it true?

"I'm an OB man. I've got a couple of patients right now whom I never agreed to accept. They were born yesterday. Suppose I refuse to treat them. Can't I be sued if something goes wrong?"

The speaker is a Texas obstetrician. But the question he raises has no geographic limits. Lawyers everywhere are often asked about the attending physician's legal responsibility for the care of newborn infants, according to Philip R. Overton, legal counsel for the Texas Medical Association.

Overton has now given his state's doctors a clear definition of their responsibility toward the newborn. What he has to say is equally valid for physicians in many other states. Here's the gist of it:

Whatever the circumstances, the baby you deliver is *your* patient legally until another physician actually takes over his care. Says the Texas attorney: Unless you provide the necessary care from the moment of birth, you

may be liable "if, as a result of such 'abandonment,' the child suffers injury."

"Abandonment" is the law's rather melodramatic description of the situation. It applies where the physician isn't immediately available when something unexpectedly goes wrong with one of his patients.

It means that once you accept a case, you must stay with it until you're dismissed, until the patient has recovered, or until you give him formal notice that you want to withdraw. And in this last event, you must allow him reasonable time to find another doctor. Otherwise, you may be open to a charge of abandonment.

That general rule holds good whether the patient is 25 years or 25 minutes old, says Philip Overton.

Legally, you can refuse to accept a patient who's pregnant. Or, having accepted her, you can refuse to deliver the child—provided you give her advance no-

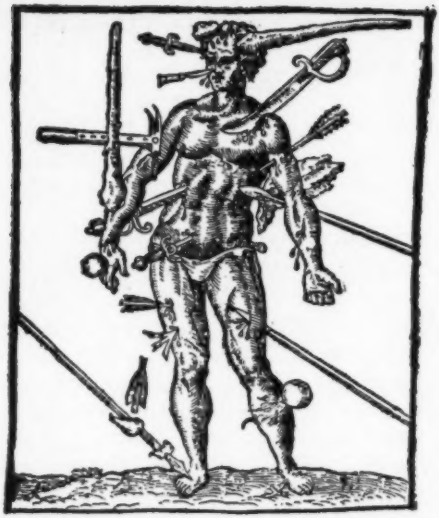
GET AWAY FROM THAT DESK!

Do you stay seated behind your desk when interviewing patients? Then Dr. Abraham G. White, a New York internist, has news for you. Some time ago, he tried this simple experiment:

On Mondays, Wednesdays, and Fridays, he got up from behind his desk and talked with patients while sitting next to them. On Tuesdays, Thursdays, and Saturdays he returned to his old spot behind the desk. Every day, he kept tabs on the attitudes his patients exhibited. His finding: The office desk can be a real barrier between doctor and patient.

When no desk intervened, he found, 55 per cent of his patients relaxed in spite of their ailments. But whenever Dr. White assumed his usual professional perch, only 11 per cent of them were at ease. He discovered, too, that the patients who relaxed remembered more details of their medical histories than those who were keyed up.

Getting away from the desk, he concluded, lessens patients' tension and makes possible more reliable clinical histories. END



Wound Man from 16th-century Surgery of Ambroise Paré

tice that she'll have to get another doctor.

But once you've delivered the baby, you've undertaken to treat it. You're legally responsible for its care even if you have merely substituted for the attending physician at the time of birth.

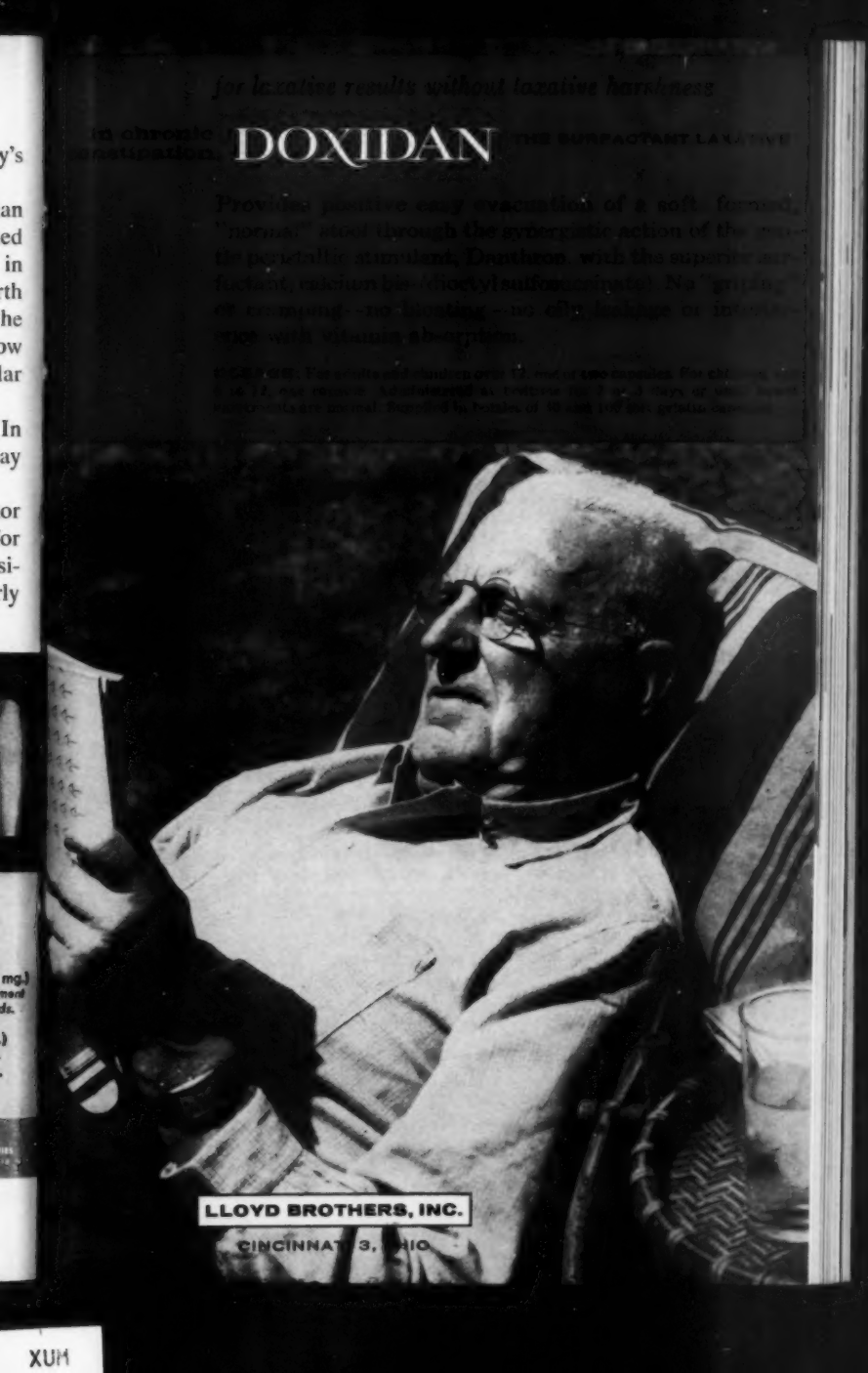
He Had No Excuse

In a Kentucky case, a substitute doctor who was called to make a delivery was later charged with abandonment. Here's why: The child lost his eyesight, allegedly because the doctor had failed to place silver nitrate in the newborn baby's eyes.

In his defense, the physician pointed out that he'd been called in an emergency. He'd been in attendance on another childbirth at the time. So he felt he shouldn't be expected to show the same diligence as the regular attending physician.

Not so, ruled the court. In ordering the doctor to pay $5,000 damages, it said:

"Since the substitute doctor had accepted responsibility for the case from the family physician, it was his duty to properly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... is effective by itself in a majority of patients with mild or moderate hypertension, and even in many with severe hypertension

care for the child. But he neglected this duty."

Most abandonment troubles stem from the lack of a firm agreement between doctor and patient. That's why Overton emphasizes that you should have a definite understanding with the mother-to-be, not only about her own future care but about the care of the baby as well.

In the absence of any such prior agreement, Overton points out, the law holds you equally responsible for medical services to both mother and child.

When Can You Bow Out?

And how long are you then responsible for the baby's care? Overton's answer: "Such responsibility certainly extends through the period that the mother and child are in the hospital. In all likelihood, it would also be deemed to last as long as the mother is under your care for reasons incident to the delivery."

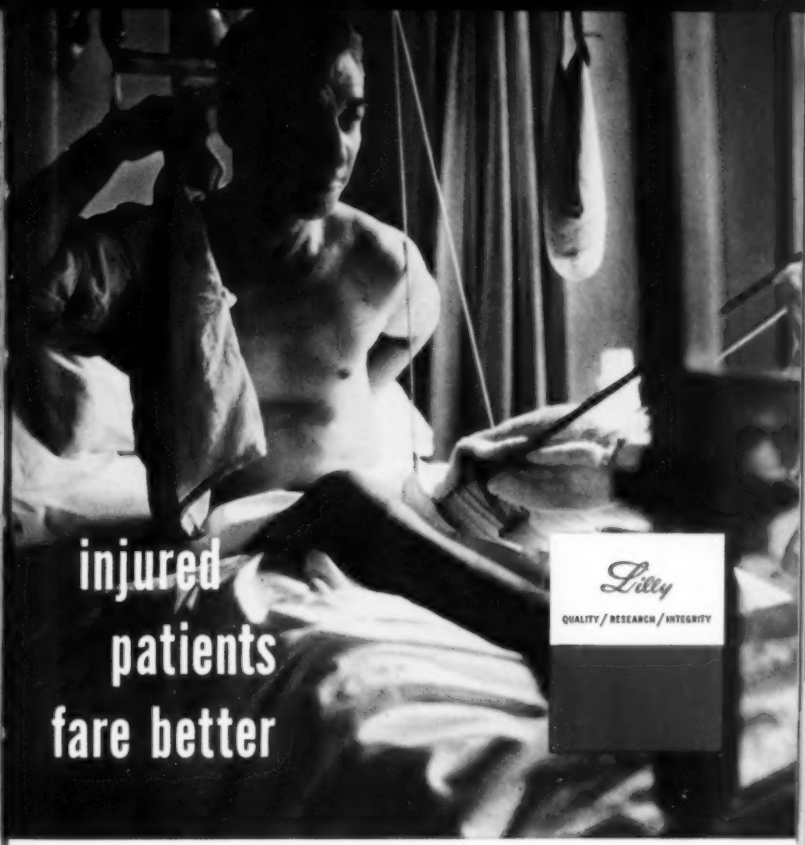
What about the OB man who limits his practice? How can he limit his obligation to care for the newborn child?

Says Overton: "A physician has a legal right to restrict or limit the medical services he will render. But this fact should be clearly understood and agreed to by the patient well in advance of the delivery, so that she'll have an adequate opportunity to obtain another physician to care for the child."

Let's assume you've agreed that a pediatrician will be called in. You're still obliged to continue caring for the infant until the pediatrician actually takes over. Even though the other doctor has already accepted the case, "you may be risking liability for abandonment," says Philip Overton, "if you fail to care for the child between the time of delivery and the time the pediatrician takes charge."

The pediatrician has some legal obligations too. Once he accepts the case, "he must make his medical services available as soon as possible after he's been notified of the delivery," Overton explains. "Failure to do so may subject the pediatrician to liability for abandonment."

But if you're the delivering physician, there's apparently only one safe course for you: Even if the mother has accepted in advance whatever limitations you put on your practice, stick with the baby until another doctor has *in fact* taken over. END



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Becotin with Vitamin C provides therapeutic amounts of the water-soluble B complex and ascorbic acid plus all the vitamins naturally occurring in desiccated liver and stomach tissue. Prescribe 3 Pulvules® daily following severe injuries; reduce dosage as patient improves.

1. Hayes, M. A.: Water-Soluble Vitamin Requirements in Surgical Convalescence, Ann. Surg., *140*:661, 1954.

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In a study on hypertension, Ultran was valuable in relieving anxiety and tension.[2] In geriatric agitation, Ultran has been observed to be helpful in calming 82 percent of moderately agitated senile patients.[3] In a wide variety of common dermatological conditions, Ultran was found to provide good or excellent tranquilizing and antipruritic effects in all but one of 81 patients.[4] Also, patients with prolonged illness usually experience alleviation of emotional tension, without significant side-effects.[5]

Ultran is supplied in Pulvules® of 300 mg. (usually 1 t.i.d.) and scored tablets of 200 mg. (usually 1 q.i.d.).

1. Summary of extended clinical trial data, Lilly Laboratory for Clinical Research. 2. Rhode Island M. J., *40*:514, 1957. 3. Geriatrics, *12*:607, 1957. 4. Illinois M. J., *112*:273, 1957. 5. Am. Pract. & Digest Treat., *9*:397, 1958.

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When NOT to Send a Patient to a Psychiatrist

'Don't oversell my specialty!' says this psychiatrist. 'Beware of referring the patient who doesn't want my services'

By R. V. Fitzgerald, M.D.

We psychiatrists depend on referrals just as any other specialist does. But don't waste your time and ours by referring patients who don't want our services! It's surprising how many doctors do just that.

Some of my colleagues, for instance, are too enthusiastic about psychiatry for their patients' own good. Such an enthusiast is an internist I'll call Dr. Leonard. He telephoned me the other day:

"Dr. Fitzgerald, this is Dr. Leonard. I have a Mr. Brown in my office, and I've told him he should see you. He needs it badly. When can you make an appointment?"

"Does the patient want to see me?" I asked in return.

"Oh, don't worry about that," Dr. Leonard answered. "Mr. Brown will follow my advice."

Reluctantly, I set a date for an appointment. But I laid aside some paper work to do in the free hour, just in case the patient didn't show up.

He didn't. Why not? Well, besides his enthusiasm for psychi-

atry, Dr. Leonard has a strong personality. He'll beat a patient into a kind of transitory submission and make an appointment with the psychiatrist. The patient seems to agree, but later he's apt to change his mind.

So I tell my doctor-colleagues, "Don't oversell psychiatry to your patients!" I try to give them pointers on when it may be wiser *not* to refer a patient. And my experience with Dr. Leonard illustrates my first such pointer:

Don't refer a patient to a psychiatrist if you need to use high-pressure tactics to get him there.

Naturally I'm not talking now about the mental patient who needs to be hospitalized, or any patient who's incapable of making a decision for himself. In such situations, the doctor or a relative must decide about treatment, and fast.

But it's not that great an emergency with patients who are just emotionally disturbed. Since they have minds of their own, any doctor wastes his time when he *orders* them to see a psychiatrist. Only they themselves can make the ultimate decision to get our help.

Several weeks ago I spent thirty minutes on the telephone with a frantic wife. She had just consulted her family physician about a nervous headache. She had discussed her worries with him, and she now repeated them to me:

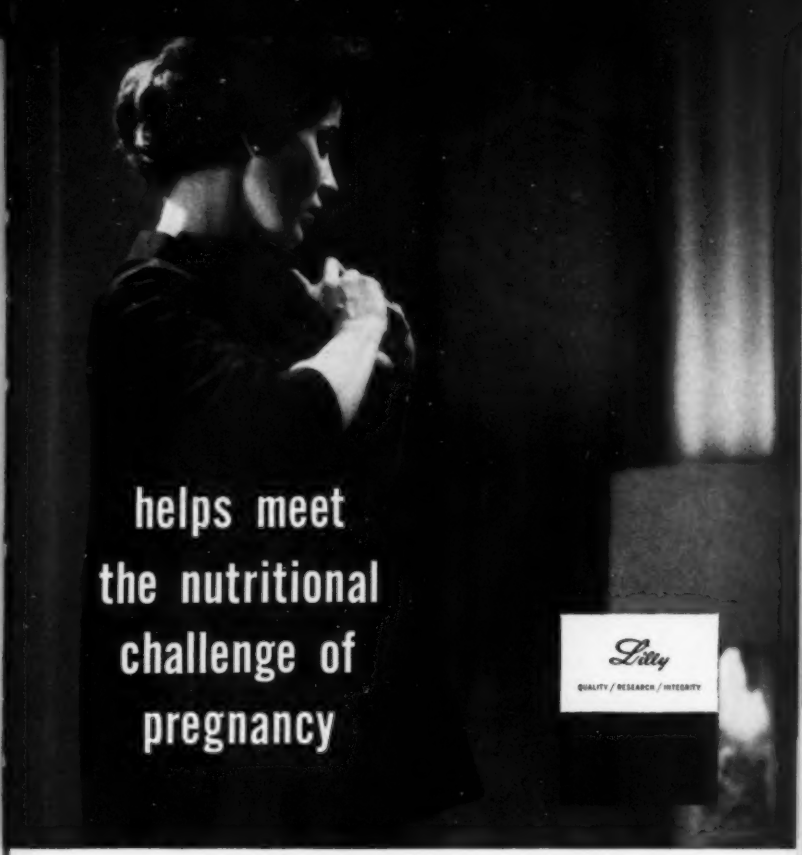
Her husband was selfish, inconsiderate, and unfaithful. He had been this way for all twenty years of their married life. Why was she calling me? Because her doctor had told her, "I know a psychiatrist who could straighten your husband out." When might she tell her husband I'd see him?

"I think you'd better talk it over with your husband first," I suggested. "Then he can call me for an appointment if he wishes." I explained why it was important that her husband take the step himself.

"Psychotherapy depends on the cooperation of the patient," I said. "And even with a deeply interested patient, while we might be hopeful, we could make no promises regarding results."

Needless to say, I never heard from the husband.

Now, what error had the family physician made? Well, I think he was applying surgical principles to an emotional case. If the appendix (or husband) is causing trouble, cut out the trouble, treat it, do something about it. But I



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LILLY VITAMINS..."THE PHYSICIAN'S LINE"

suspect that the wife wanted no more than a sympathetic listener.

Her doctor was sympathetic, all right. But in his therapeutic zeal he did too much. He gave impossible advice, and he oversold psychiatry in the bargain.

That's why I say physicians and relatives can't help the neurotic patient by making a psychiatric appointment for him behind his back. It won't stick. And here's another caution I often urge on doctor-colleagues:

Don't promise quick results when you refer a patient to a psychiatrist.

Recently, a woman in her early thirties came to see me about what she called her melancholy spells. She said they'd been recurring every week or so since her college days. As our first interview ended, she asked me how many more treatments would be needed. I tried to explain that this was hard to predict, especially with a new patient.

To avoid a definite commitment, I told her, "You've been experiencing these troubling symptoms for about ten years now. Perhaps the roots go back even earlier. We can't expect to clear up something so long-standing in a few weeks."

"But the doctor who sent me told me four or five visits should do it," she said in surprise.

Now, her doctor is an intelligent, well-informed internist. I can't imagine that he's ignorant of the time required for treating a serious neurosis. What had happened, then?

Probably the internist thought his patient would be upset about going to a psychiatrist. So he tried to cushion the blow by minimizing the painful facts. But this is like telling a frightened child that he won't feel the needle.

In the long run, the truth would be kinder: Few psychiatric disorders respond to a crash program.

I also keep urging my colleagues to prepare the patient for the fact that psychotherapy doesn't always succeed.

"You wouldn't assure a patient with carcinoma that an operation would cure him once and for all," I remark. "It's equally unjustified to promise a patient with an emotional disorder that a psychiatrist can 'fix him up.'"

True, you doubtless know of patients who say they felt better after just one visit to a psychiatrist. Perhaps that's because he gave them some words of reas-

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Also: Sandril, as tablets of 0.1, 0.25, and 1 mg., and elixir, 0.25 mg. per 5-cc. teaspoonful.

1. Geriatrics, *12*:185, 1957.
2. J. Indiana M.A., *48*:603, 1955.

Pyronil® (pyrrobutamine, Lilly)

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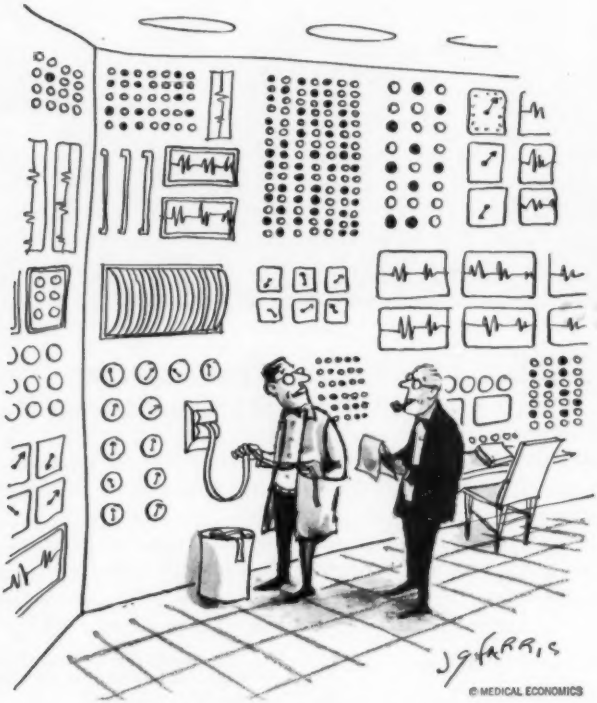
surance that they needed—words that were overdue. Which brings me to my next suggestion:

Don't refer a patient to a psychiatrist for reassurance that you yourself are better equipped to give him.

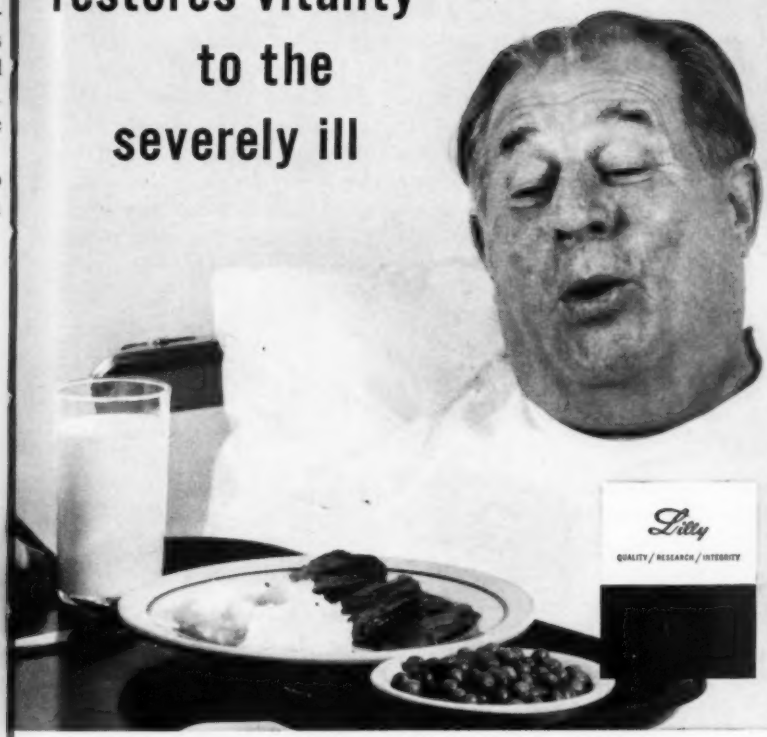
That point may seem obvious. Who would refer a patient unnecessarily? Well, some doctors do. Possibly they hope to get rid of a perplexing patient that way. They may even do it to please the patient.

A middle-aged man came to see me the other day about a



"It doesn't feel well. It wants a doctor."

restores vitality to the severely ill



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1. Kaye, Robert: Vitamins and Other Nutrition Factors in Clinical Practice, Delaware M.J., 28:51, 1956.

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moderately severe chest cold—although he knew I was a psychiatrist. "I told Dr. Blank I was going to see you and he said to go ahead," the patient began. "He has just given me what he calls a check-up. But he didn't find any reason for the colds I'm always getting. I thought maybe you could."

I asked him to tell me more about the check-up. Replied the patient: "The doctor just listened to my heart and lungs and took my blood pressure. He didn't go any deeper."

"How do you mean, 'deeper'?" I asked politely.

"I mean he didn't bother to take an X-ray or an electrocardiogram."

Arguing with the gentleman would have got me nowhere. He was worried about a chest cold, and he felt sure his doctor's examination had been cursory. So he came to me—perhaps in protest.

At my suggestion, the man went back to his own physician. Meanwhile I phoned the doctor and alerted him. Result: The patient got his X-ray and his ECG. He didn't consult me again about the psychology of his chest cold. He didn't need to, now that he was satisfied he had the full attention of his regular doctor.

So much for the person who needs your reassurance, not my psychiatry. There's another category of patient you doubtless wouldn't refer to me. Yet, strange as it seems, some doctors do. He's the person with an ailment that might turn out to be psychosomatic—but also might be organic.

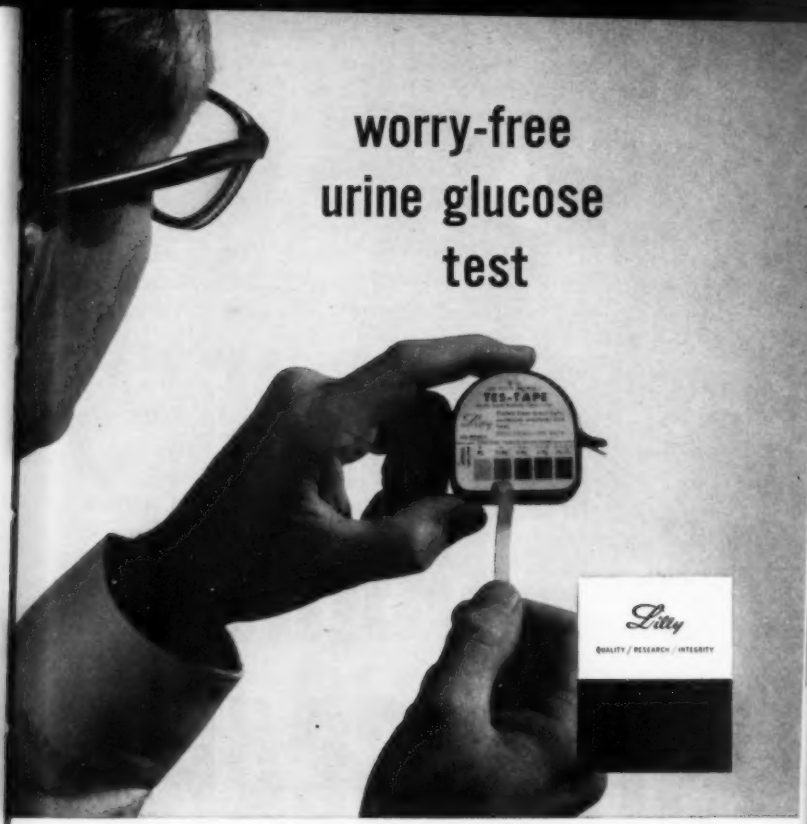
For example, let's say a patient has difficulty in swallowing. A doctor could nod sagely and call the trouble a nervous spasm.

But what if it's a tumor of the esophagus? Clearly, an esophagoscopy and a barium swallow are called for here, before the psychiatrist is invited into the picture.

As I say, that precaution may seem obvious to you. Yet it's not always taken. More than one person has been referred to a psychiatrist, only to have the psychiatrist unearth a physical cause.

Don't refer a patient to a psychiatrist for treatment of a personality problem unless the patient wants it treated. And don't risk trying to treat it yourself.

Give someone who hasn't asked for it a glimpse into his emotional mechanism, and you



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1. Whipple, R. L., Jr., and Bloom, W. L.: J. Lab. & Clin. Med., *36*:635, 1950. 2. Parker, F. P.: A Textbook of Clinical Pathology, Ed. 3, p. 568. Baltimore: The Williams & Wilkins Company, 1948. 3. Seltzer, H. S., and Loveall, M. J.: J. A. M. A., *167*:1826, 1958.

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may do more harm than good. For instance, say you have a patient who's too self-effacing. You've a pretty good idea what's behind the young man's painful shyness. His basic problem, you figure, is his domineering mother.

"Probably he hates her," you think to yourself, "and he has too much guilt to admit it."

Maybe. But if you treat your patient to all that insight at once, you invite serious trouble.

Encourage Him to Talk

Fortunately, there's a safer approach the doctor can take with a patient who seems to need the help of a psychiatrist but hasn't asked for it. If the patient is really as troubled as you suspect, a tactful question or two will often start him talking. Once he's told you something about his emotional difficulties, the conversation can turn to whether he should see a psychiatrist.

That's the tactic I recently recommended to a G.P. who went to medical school with me. Dr. Stebbins, as I'll call him, telephoned me from a distant city to talk over the difficulties he was having with a postoperative case. His patient, a young man, wasn't recovering as rapidly as would be expected from an uncomplicated appendectomy.

Why Recovery Was Slow

"The boy is tense—apparently worried about something," Dr. Stebbins reported. "And he seems overly dependent on me. One other thing: I've noticed that he's somewhat effeminate in his gestures. Should I bring my suspicions out in the open and have a frank talk with him about homosexuality?"

"It would be safer to keep it more general," I replied. "Perhaps you could mention his worried expression and ask him if anything's on his mind. You may be quite right about the homosexual tendencies. But your patient may not be aware of these tendencies; or he may be aware of them, but not be ready to discuss them.

'Supportive' Treatment

"Usually when we psychiatrists treat such a patient," I went on, "we follow what we call a supportive approach. This frees the patient to ventilate his problem and eventually to decide on his own goals. In other words, we approach the problem in several stages.

More▶

"The patient isn't faced with it bluntly."

Several days later, my colleague called back to report on his interview with the post-op patient.

The doctor had merely asked a few sympathetic questions without doing any specific probing. The young man reacted by volunteering what he was worried about. He'd been struggling with homosexual impulses for some time. He told of his self-consciousness and his feeling of guilt.

"You should have seen the relief on his face as he was telling me this," Dr. Stebbins related. "Then, on his own, he asked me if he should see a psychiatrist. I told him to think it over and we could talk about it later. The main thing now, I said, was to make a good recovery from the operation."

Later, when the patient was back on his feet, he called on Dr

THESE VACATIONS

How would you like to get paid for summering at a resort hotel? Or to send your children to camp without its costing you a penny?

If you don't mind working quarter- to half-time during your vacation, bargains like this are still available. The trick is to sign on as summer physician for any of several hundred resort hotels or several thousand children's camps scattered across the country. In some cases, you can sign on for as little as two weeks.

The hotel jobs, being more glamorous, are the harder to get. Few resorts advertise their vacation-with-pay plans. And by no means all even have them. But

Stebbins. He asked my colleague to recommend a psychiatrist in the town where the young man was studying.

Meanwhile, of course, Dr. Stebbins had already achieved what he was after: the patient's successful recovery from the operation. The doctor's friendly, permissive manner had been the support the patient needed for his convalescence. And that's typical of the good results I've observed when attending physician and psychiatrist put their heads together.

Why not try the same technique next time you're in doubt about how to proceed with a perplexing patient? Don't refer the patient right off. First avail yourself of a free curbstone consultation with your psychiatric colleague. If he's like me, he spends too many hours in fruitless consultations with the wrong patients. He'd far rather talk with you! END

PAY FOR THEMSELVES

BY EDWIN N. PERRIN

those that do are well worth hunting for. Typical is the post that Dr. Jack Manpel of Flushing, N. Y., will be taking over a few weeks from now. It's at the Tamiment, a big resort hotel in Pennsylvania's Poconos.

To regular guests, the Tamiment makes an inclusive charge of $100 a week. For his two weeks, Dr. Manpel will be charged nothing. He's also entitled to $25 weekly credit toward his wife's bill. (Actually, because they've gotten to be regulars—this'll be their third summer—the Tamiment isn't charging anything for Mrs. Manpel this year.)

What does the doctor do in return? He gives advice and minor

treatment for an hour after every meal. That's a total of three hours a day. If a guest gets really sick, he's whisked off to a doctor in town. If a prescription needs to be written, the local M.D. writes it. Dr. Manpel doesn't even need a Pennsylvania license. "About all I *do* need," he says, "are my bag and my tennis racket."

One caution before you start looking for a similar spot: Most hotels don't want the doctor's children around. And some hotels, mindful of their younger female guests, prefer doctors with-

Amusing . . .
Amazing . . .
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No doubt one of these adjectives describes some incident that has occurred in the course of your training.

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out wives. They've absolutely no objection to your picking one out while you're there, though.

Camps Pay More

Camp work is usually a bit more demanding than being doctor at a resort. That's why it's better paid. Camp doctors usually get $75 to $100 a week plus board, room, and laundry. In return they usually devote between three and five hours a day to the kids' medical needs. The rest of the time is for swimming, fishing, or whatever the doctor pleases.

Most camps will take a physician's wife at no extra charge. A few will also take his camp-age child for free. The more usual arrangement, though, is to balance off one child against half the salary, or two against all of it. Thus you could get an expense-paid vacation for your wife and two children, plus a half-vacation for yourself.

"Make no mistake, though: There's plenty of work for a camp doctor to do," says one

The power of speech

Mrs. Johnson was a strong-minded farm woman who felt she should supervise her daughters through childbirth. Sometimes, naturally, her medical opinion clashed with that of the doctor.

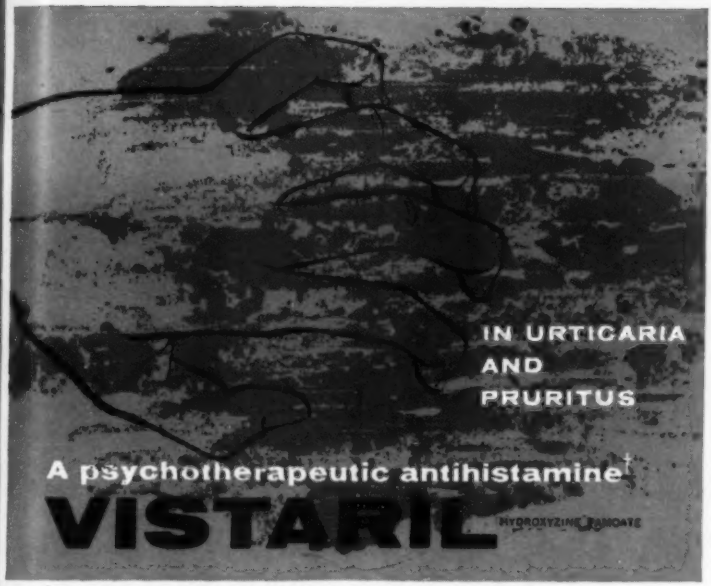
And it did this time, when, after examining one of her daughters in labor, the doctor found the baby to be in a posterior position. He announced he'd have to take the girl to the hospital for a forceps delivery.

"Now, Doc," said Mrs. Johnson, "I don't think that's at all necessary. When she had her first child, the doctor just sat by her bed and talked that baby right out of her."

"Madam," replied the doctor, "I can see how a man might talk a baby into a woman, but I defy any man to talk this baby out of one."

—BEN B. RADER, M.D.

For each previously unpublished anecdote accepted, MEDICAL ECONOMICS *pays $25 to $40. Address: Anecdotes, Medical Economics, Inc., Oradell, N. J.*



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relieves—tension, anxiety and itching.[1-4]

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References: 1. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 2. Eisenberg, B. C.: Clinical Medicine *5*:897-904 (July) 1958. 3. Robinson, H. M., et al.: J.A.M.A. *161*:604-606 (June 16) 1958. 4. Robinson, H. M., et al.: So. Med. J. *50*:1282 (Oct.) 1957.

pediatrician who has put in parts of a couple of summers. "You're up for breakfast by 7, and your schedule runs seven days a week. But at least there are no house calls and no jangling telephones. That's what makes it seem like a real vacation to me."

How About This Year?

Are short-term camp jobs still available for this summer? Yes, they are. Every camp would prefer to get a doctor for the full eight-week season. But many can't. These camps will cheerfully sign you on for a month—or even two weeks if they get desperate.

"They'll say a month is the minimum," says a Baltimore M.D. with recent camp experience. "But the closer it gets to the first of July, the easier it is to pick up a spot for two weeks."

And where do you pick up a camp spot? The American Camping Association (342 Madison Ave., New York City) fills some 2,000 openings for physicians annually. You can register with them by mail; there's a $1 fee.

In addition, the Association of

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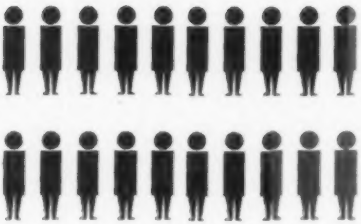

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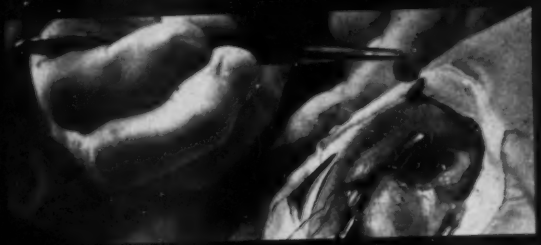

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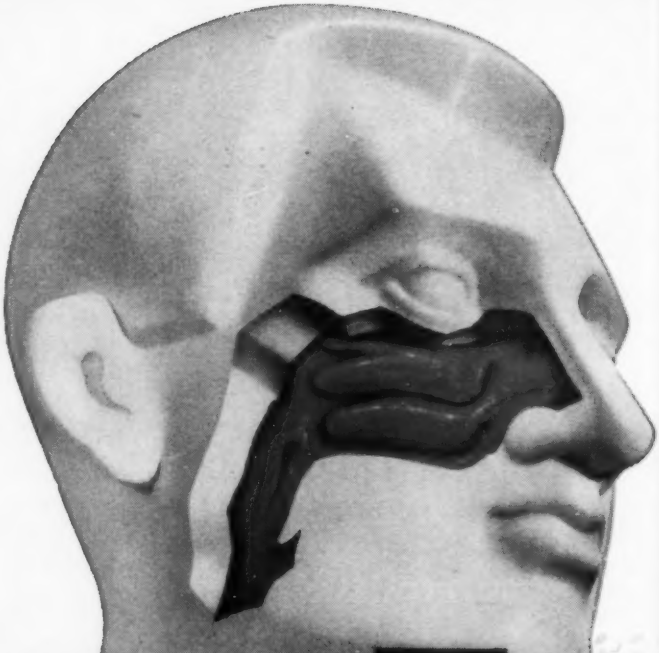

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Private Camps (55 W. 42nd Street, New York City) says it will generally take all the M.D.s it can get. Register by mail; there's no fee.*

Now, what if you hate resorts, can't stand children, and still want a paid vacation?

Holiday Afloat

Well, there's one steamship company that takes on ship's surgeons for just fifteen days—just long enough for one round trip from New York to Panama via Haiti. You get free passage plus $15 a day, and you may not take your wife. There are forty-two sailings a year and thus forty-two openings.

If you'd like to fill one of them, write to Dr. Jerome A. Schack, medical director of the Panama Steamship Line, 975 Park Avenue, New York City. Young specialists fresh from hospital training in the general specialties (internal medicine, general surgery, etc.) are preferred. But the line has employed other types. Because the demand is pretty fierce, better expect a six- to eight-month wait between the time you apply and the time you actually sail—if you're lucky, that is. END

*Both the above associations serve as clearinghouses. The physician makes arrangements with the individual camp director.

HERE'S HOW TO MAKE IT PAY

By Charles Miller, M.D.

Every doctor, it seems to me, needs one room in his house where he can enjoy solitude in the company only of his books and journals. Such a den gives him a chance to read without interruption—a place to go for either counsel or consultation. Under the right circumstances, it even gives him an extra income tax deduction.

But the doctor's study is tax fraud—nothing less—if he doesn't have a good system for using it. I've made it a rule to spend at least an hour in my study every evening. And once secluded inside, I've hit on some other rules to make the time really pay off.

Whether or not you have a study, you have the problem of selecting what you want to read from the mountain of material available. One good rule, in my experience, is to read mostly the newer medical books and the older general books. Here are three other rules that work well for me:

1. Read with a purpose. Every man's interests tend to form a mental channel; the object of his reading is to deepen and

broaden that channel. Beware of reading matter that's utterly unrelated to your own experiences.

Why Collect Junk?

The habit of devouring great chunks of matter in which one is not particularly interested reminds me of an amateur collector I once knew. He accumulated stamps, books, cut glass, anything and everything. "Some day this stuff may be worth a lot of money," he told me.

It never was. Because he bought less from a genuine interest than from the fear he might overlook something, he merely filled his attic with junk.

Just as mentally debilitating is the habit of picking up a piece of reading matter every time you have five minutes between appointments. This is the surest means of driving away any thoughts of one's own. A novelist once told me he wouldn't read even a newspaper early in the morning; for his mind then had been emptied and refreshed and he was ready to start the most creative part of his day.

I've found that when I was wrestling with a difficult diagno-

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Kenacort safely starts your patients off right — with all the benefits of systemic corticosteroid therapy and few side effects to worry about. Increased corticoid activity is provided on a low dosage schedule[1-3] without edema,[1-4] psychic stimulation,[1-3] or adverse effect on blood pressure.[1-3,5] A low sodium diet is not necessary.[4,5] Gastrointestinal disturbances are negligible[2,4,5] with less chance of peptic ulcer.[4] This makes Kenacort particularly valuable in treating your "problem patients" — such as the obese or hypertensive and the emotionally disturbed.

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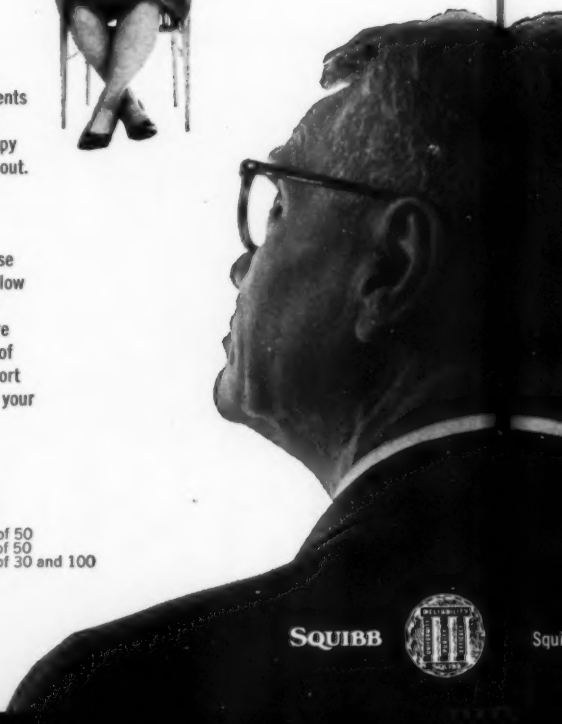

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for all your allergic patients requiring corticoids

Kenacort, in treating your allergic patients, has proved effective where other steroids have failed. In asthma, its potent antiallergic and anti-inflammatory properties improve ventilation and increase vital capacity.[2] Dyspnea and bronchospasm are usually relieved within 48 hours, and sibilant râles often disappear. Because of its low dosage[1-3] and relative freedom from untoward reactions,[1-5] Kenacort provides corticosteroid benefits to many patients who until now have been difficult to control. It is particularly valuable for allergic patients with hypertension, cardiac disease, obesity and those prone to psychic disturbances.

References:
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sis, my faculties were blunted by reading more than necessary to dig up some specific fact. At such times, reading is only second-hand thinking.

2. Don't give yourself entirely into an author's hands. Stop and recall experiences that confirm or run counter to the words of the author. Read, as Bacon counseled, "not to contradict and confute, nor to believe and take for granted, but to weigh and consider."

I try to follow Mortimer Adler's advice: Locate the basic propositions in a book, then write them down on a flyleaf or in a notebook. My method is to have a red pencil at hand and underscore or bracket significant passages. Sometimes I write brief comments in the margin. If the book or periodical is not my own, I use a loose-leaf notebook.

3. Devise a simple system for nailing down the important facts in your reading. I usually mark journal articles that I expect to refer to later and have them clipped. My secretary indexes the clippings on 3″ x 5″ cards for filing. (It's not usually necessary to index articles in the journals I keep permanently, since most professional periodicals publish cumulative indexes.)

And don't worry because you fail to remember everything you read. It's as impossible to retain every printed word as it is to retain all the food you ingest. Even what you've forgotten has served its purpose if it has nourished your mind and become a part of your thinking.

If, that is, you've been able to *think* while you read. I couldn't do it without my daily hour in my secluded study. END

First things first

When a nurse I know entered the patient's room, she was astonished to see him holding a Foley catheter.

"How on earth did you ever get it out?" she asked.

"Never mind that," the patient said. "How on earth did they ever get it in?" —HELEN THORSTENSEN, R.N.

Your patients should know

THE TRUTH ABOUT E

They want sheerness . . . but you're interested in support. There's only one way to get both!

What about the new stretch nylons that claim to be Support Hosiery—do they really work?

How can your patients be sure they're getting all the support you want them to have?

There was a time when you had trouble getting patients to wear elastic stockings because they weren't sheer enough.

Fortunately, this is no longer a problem. Today elastic stockings are made so as to be almost undetectable.

But now there's another fly in the soup . . . and this one has to do with *support*.

Specifically: the new support hosiery made *without* rubber.

The blunt fact is, this so-called support hosiery just can't do the complete job that stockings made with rubber do.

Why?

ELASTIC STOCKINGS

No substitute for rubber

An elastic stocking works by the elasticity of rubber (the way a rubber band stretches and contracts . . . or a rubber ball bounces).

In much the same way, the rubber in real elastic stockings "bounces back" to give necessary support. Only rubber offers this continuing return-action.

But the new support stockings contain no rubber. Sure, they stretch . . . but they keep right on stretching like the stretch nylons they are.

The only true support

Your patients can get the kind of support you want them to have only with the *elastic* kind of elastic stockings . . . made with rubber.

So next time you prescribe "elastic stockings," explain the *difference* that the rubber in real elastic stockings makes.

Bauer & Black, the world's largest maker, offers a complete range of styles—for work, for informal living, or for dress-up occasions (*as sheer as 51 gauge*). And each is truly elastic . . . with rubber in every supporting thread.

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The response to an antidiarrheal preparation is directly linked to the effectiveness of its adsorbent. In both POLYMAGMA and POLYMAGMA Plain, the new agent Claysorb* gives you a previously unattainable adsorptive power . . . proved to be five times beyond that of kaolin in removing diarrhea-causing toxins. In addition, POLYMAGMA and POLYMAGMA Plain protect the irritated intestinal walls, promote well-formed stools, help restore healthy intestinal function.

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For bacterial diarrhea—
bactericidal against many pathogens

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by
Philadelphia 1, Pa.

The Facts About Lloyd's Malpractice Insurance

Continued from 72

But there seems little doubt that the decision was influenced by dark warnings from insurance commissioners. The move to abandon Lloyd's was led by C.A.P. President Charles P. Larson of Tacoma, Wash. One of his remarks may well reflect the anti-foreign sentiment of many state officials:

"If a man should appear at your door and hand you a subpoena indicating that you are the defendant in a medical malpractice suit . . . would you consider it adequate to get a letter off to some company, say in the East or in England, apprising it of the situation, and hope that the company would eventually reply?"

That question evidently worries a good many other medical men. Consider, for instance, the experience of the American Urological Association.

The urologists have had a Lloyd's policy ever since 1957. They pay from $80 to $400, depending on where they practice, for $100,000/$300,000 limits. In states where companies belonging to the National Bureau of Casualty Underwriters charge twice as much for similar coverage, the savings are impressive. But only 300 of the association's 1,700 members signed up during the first 18 months of the program.

"It *must* have been the influence of the state insurance commissioners," says the administrator of the program. "I can't understand why a man would pay twice as much for malpractice insurance as he needed to—unless he distrusted the local status of the issuing company.

"But now we're putting on a campaign to show them they have something worth taking advantage of."

'Fronts' for Lloyd's

So the fact that some states discriminate against Lloyd's as a foreign carrier accounts for its difficulties with several specialty societies. Unlike the pathologists, however, three other groups have actually managed to stick with Lloyd's even while giving it up. Here's what's been done by the Academy of Ophthalmology and Otolaryngology, the Academy of Dermatology and Syphilology, and the College of Chest Physicians:

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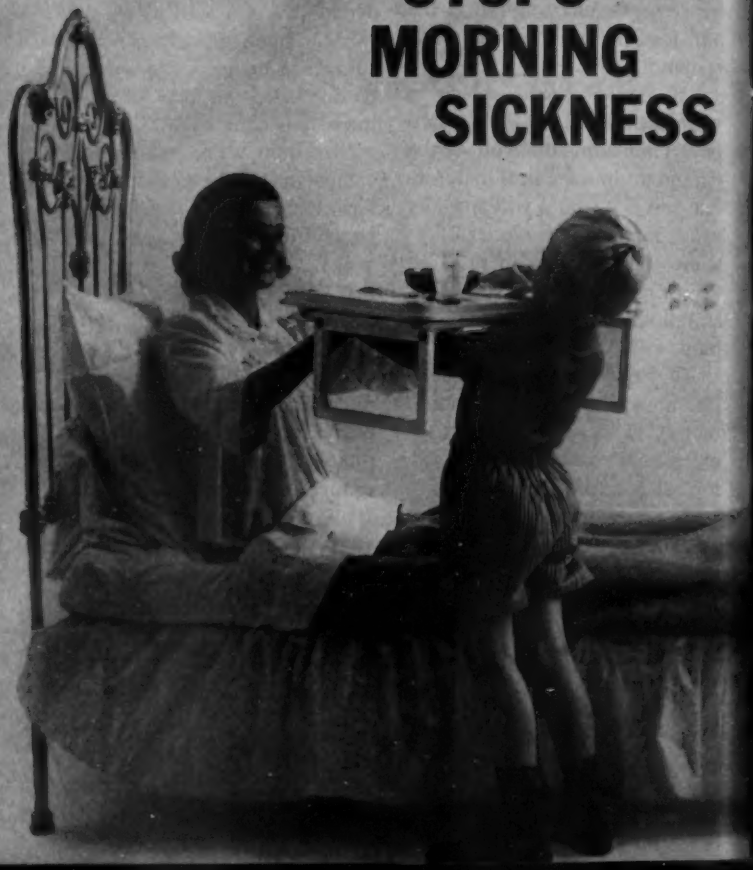

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ADOXIN®

(tablets and drops)

BONADOXIN Tablets relieve nausea and vomiting of pregnancy in 9 out of 10,[1-7] often within a few hours.

Moreover, a controlled study of 620 cases reported that with BONADOXIN "toxicity and intolerance [are] zero."[1] BONADOXIN is rarely soporific. It is free from the risks associated with overpotent tranquilizer-antinauseants.

NOTE: BONADOXIN has also been shown highly effective in relieving nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis, and motion sickness.

Each tiny pink-and-blue BONADOXIN tablet contains:

Meclizine HCl (25 mg.) . . . for antivertiginous, antinauseant effects.

Pyridoxine HCl (50 mg.) . . . for specific metabolic replacement.

DOSAGE: usually one tablet at bedtime. Severe cases may require another dose on arising.

SUPPLIED: tiny pink-and-blue tablets, bottles of 25 and 100. Fruit-flavored, clear green syrup in 30 cc. dropper bottles.

Infant colic? BONADOXIN DROPS are antispasmodic... stop colic in 84%,[8-10] without the risk of belladonna and barbiturates.

Each cc. contains:
Meclizine dihydrochloride .. 8.33 mg.
Pyridoxine hydrochloride ...16.67 mg.

Dosage:

under 6 months . . . . 0.5 cc.	2 or 3 times daily, on the tongue, in fruit juice or water
6 months to 2 years . . . . 1.5 to 2 cc.	
2 to 6 years . . 3 cc.	
adults and children over 6 . . . . . 1 tsp. (5 cc.)	

References: 1. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957. 2. Groskloss, H. H., et al.: Clin. Med. 2:885 (Sept.) 1955. 3. Weinberg, A., and Werner, W. E. F.: Am. Pract. & Digest Treat. 6:580 (April) 1955. 4. Crawley, C. R.: West. J. Surg. 8:463 (Aug.) 1956. 5. Tartikoff, G.: Clin. Med. 3:223 (March) 1955. 6. Dunn, R. D., and Fox, L. P.: Clinical exhibit. 7. Codling, J. W., and Lowden, R. J.: Northwest Med. 57:331 (March) 1958. 8. Dougan, H. T.: Personal communication. 9. Leonard, C. L.: Personal communication. 10. Steinberg, C. L.: Personal communication.

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

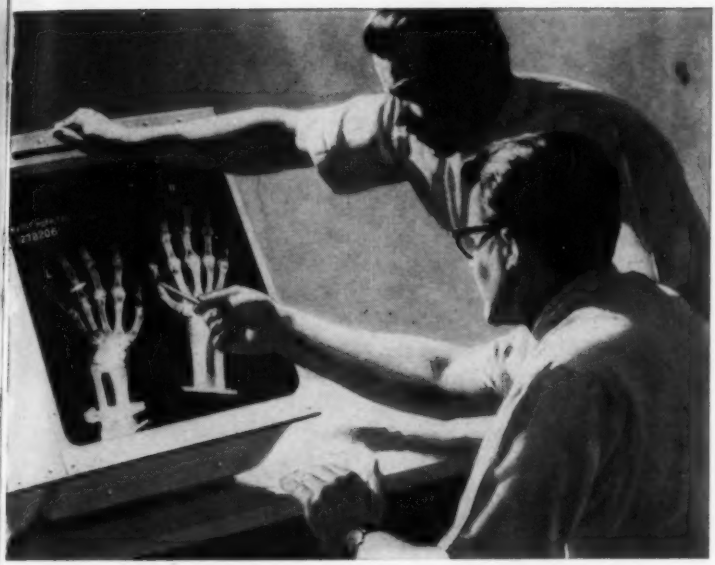
They've switched to domestic companies that write their contracts *with heavy reinsurance from Lloyd's.* Such an arrangement makes use of a "fronting" company—an organization that's able to meet the requirements of most state insurance departments.

The fronting company can offer lower premiums to doctors in places like Oregon and California, where Lloyd's isn't permitted to set rates that compete with those of domestic carriers. And some fronting companies that don't belong to the National Bureau can offer remarkably low rates. Thus, the eye men and ENT men pay only $75 for $25,000/$75,000 coverage in most states.

U.S. Firms Preferred

A third major criticism of Lloyd's is that its decentralization further complicates the already over-complex malpractice insurance situation.

No specialty society has given up Lloyd's for this reason alone. But it's been a contributing factor in some cases. The administrator of the three programs that



in arthritis, BUFFERIN® because . . .

. . . in the majority of your arthritic cases BUFFERIN alone can safely and effectively provide adequate therapeutic control without resorting to the more dangerous cortisone-like drugs.

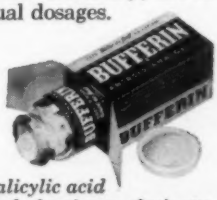
. . . BUFFERIN is better tolerated by the stomach than aspirin, especially among arthritics where a high dosage, long term salicylate regimen is indicated.

. . . BUFFERIN provides more rapid and more uniform absorption of salicylate than enteric-coated aspirin.

. . . even in the relatively few cases where steroids are necessary, use of BUFFERIN will allow proper flexibility for individual dosages.

. . . BUFFERIN is more economical for the arthritic who requires a long period of medication.

. . . BUFFERIN *contains no sodium*, thus massive doses can be safely given without fear of sodium accumulation or edema.



Each sodium-free BUFFERIN tablet contains acetylsalicylic acid 5 grains, and the antacids magnesium carbonate and aluminum glycinate.

Bristol-Myers Company, 19 West 50 Street, New York 20, New York

have switched to domestic companies says it's much easier to deal directly with an American underwriter.

"This decentralization can be mighty upsetting," he explains. "At one time, when one of these national societies was covered by a Lloyd's contract, a Lloyd's man representing another syndicate stole one of the local chapters away from the mother group. He set up a program for the local chapter at a lower premium than the national organization could arrange. That got everybody stirred up."

'Untenable Situation'

Some similar complaints have cropped up among the internists. Back in 1953, when their Lloyd's program was first set up, they had a base premium of $50 for $5,000/$15,000 coverage. Soon the same coverage was being offered to a group of doctors in Kings County, N.Y., for $31.50. "Lloyd's is creating an untenable situation!" snapped one A.C.P. member.

But regardless of all such criticisms, note this fact: Lots of doctors say they're entirely happy with their overseas underwriter.

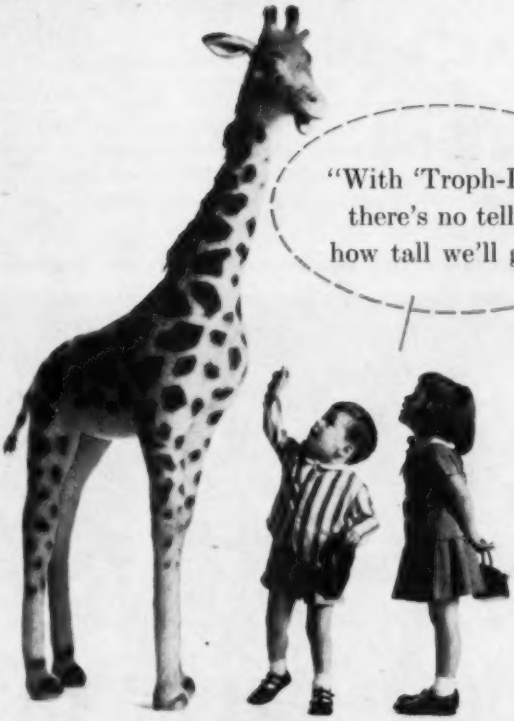
The U.S. members of the International College of Surgeons are saving money in forty-three states. In Minnesota, for instance, they're paying $78 less than National Bureau rates for $50,000/$150,000 coverage; Missouri surgeons are saving $68 on similar coverage; Wisconsin surgeons are saving $71.

They're Loyal to Lloyd's

Lower premiums have kept many other doctors faithful to Lloyd's. Among them, significantly, are great numbers of pathologists. When the College of Pathology terminated its group contract, two-thirds of the men who were covered elected to retain their Lloyd's policies on an individual basis, according to the former administrator of the defunct program.

This loyalty held despite an official notification that Lloyd's was being dropped because of a premium hike that boosted the cost of coverage "to the approximate cost of a similar policy with established American companies." Apparently, individual pathologists did some figuring and decided to disagree with their leaders.

Even with the increase, the



'Troph-Iron' not only gives a healthy boost to appetite, but also promotes growth and corrects nutritional iron deficiency in children who are underpar.

The dosage? Just one tasty, cherry-flavored teaspoonful (5 cc.) a day.

TROPH-IRON® Liquid

B_{12}—Iron—B_1

Also available: 'Troph-Iron' Tablets.

SMITH KLINE & FRENCH LABORATORIES, PHILADELPHIA

doctors realized, Lloyd's was still cheaper in most states. In fact, Lloyd's price advantage over National Bureau companies was now greater in twenty-three states than it had been in 1954. Lloyd's rates had risen—but not as fast as National Bureau's.

But price isn't all. Some pathologists have stuck with the organization because they believe the quality of coverage to be better. Says one such man, Dr. Ernest L. Abernathy of Washington, Pa.:

"We're apt to be held liable for assault on autopsy cases if the consent is questioned. Lloyd's will probably cover us in such cases. I think the standard clause of domestic policies is written so that the carrier might weasel.

"Then, too, our relationship with the hospital presents a problem. Who's liable for a technician's mistake: the hospital that pays her salary, or the supervising pathologist? I believe Lloyd's gives us more protection in such ambiguous situations. But I hope I never have to find out!"

Or consider this statement from Pathologist E. D. Levy of Norfolk, Va.:

"I had a bad suit against me —a transfusion death. Lloyd's let me pick my own lawyer, and they agreed to abide by his decision on whether to settle or fight. He decided to fight and took me through the original trial, an appeal, and finally, a reappeal. I escaped a $50,000 judgment.

They Didn't Quibble

"Lloyd's let us handle the case without interference. All they did was pay the costs, with no questions."

Finally, note that one specialty society has remained loyal to Lloyd's since 1953. Its members maintain that the organization does more to meet their unique problems than domestic carriers would. Says Austin Davies, who runs the American Psychiatric Association program:

"Psychiatrists can be sued for a number of things that might not be covered in an ordinary malpractice contract. I know of two men who were refused help by their domestic carrier because they were accused of kidnaping, not of malpractice. They'd taken patients across state lines for hospitalization.

"Others have been sued for

NOW

...a new way to relieve pain and stiffness in muscles and joints

INDICATED IN:

MUSCLE STIFFNESS

LUMBOSACRAL STRAIN

SACROILIAC STRAIN

WHIPLASH INJURY

BURSITIS

SPRAINS

TENOSYNOVITIS

FIBROSITIS

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LOW BACK PAIN

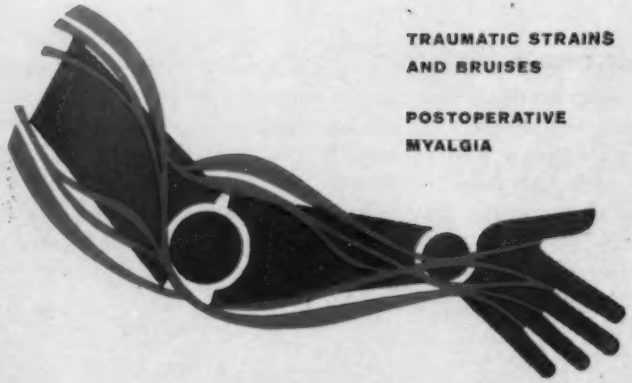
DISC SYNDROME

SPRAINED BACK

"TIGHT NECK"

TRAUMATIC STRAINS AND BRUISES

POSTOPERATIVE MYALGIA



■ Exhibits unusual analgesic properties, different from those of any other drug ■ Specific and superior in relief of SOMAtic pain ■ Modifies central perception of pain without abolishing natural defense reflexes ■ Relaxes abnormal tension of skeletal muscle

SOMA

N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

■ more specific than salicylates ■ less drastic than steroids ■ more effective than muscle relaxants

SOMA has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. SOMA is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with SOMA than with any previously used analgesic, sedative or relaxant drug.
SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

ACTS FAST. Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

NOTABLY SAFE. Toxicity of SOMA is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy on high dosage.

EASY TO USE. Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

SUPPLIED: Bottles of 50 white sugar-coated 350 mg. tablets.

Literature and samples on request.

WALLACE LABORATORIES, NEW BRUNSWICK, N. J.

wrongful advice, alienation of affection—all sorts of strange charges. But we've never had a case that Lloyd's has been unwilling to defend."

Buying by mail, the psychiatrists get a break on premiums, too. The Lloyd's rate for all psychiatrists in all states is only $70 for $5,000/$15,000 coverage—less if they do no shock therapy.

"Our particular Lloyd's syndicate doesn't handle any other professional liability," explains Austin Davies. "So our group is rated just on its own performance. We have unusually comprehensive coverage and low premiums. We wouldn't dream of leaving Lloyd's."

So, as you see, doctors' reports on Lloyd's vary from "impossible" to "ideal." What, if anything, the London underwriters could do for you seems to depend pretty much on the deal you might get from a given agency. But if you're considering Lloyd's coverage, you'll be well advised to ponder it in the light of the following questions:

To Help You Decide

1. Is the policy you're considering really a Lloyd's policy? If Lloyd's is only reinsuring or covering a percentage of the risk, are the other underwriters reliable?

2. Is the broker or agent someone you would trust even if the insurance department in your state has no jurisdiction over Lloyd's representatives? Can he show that he'll give good service in the event of suit?

3. Is there any reason why a standard domestic contract won't cover all your needs? Do you need a special sort of contract that perhaps only Lloyd's will write?

4. Exactly how much money will you save with a Lloyd's policy?

Your answers should help you decide whether your best malpractice insurance buy is foreign or domestic. END

QUESTION:

Why is Bellergal an unusually effective adjunct in functional gynecologic disorders?

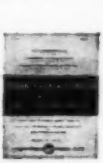
ANSWERS:

Quoted from published reports of leading clinicians.

"A more uniform and prolonged relief of tension [and other major complaints of functional gynecologic disorders] may now be obtained by use of Bellergal Spacetabs." ***(Stewart, R. H.: West. J. Surg. 64:650, Dec. 1956.)***

"...of 125 women who presented climacteric symptoms...73 responded [to a 2 to 4 week course of Bellergal therapy] so well that the dose was reduced...or the drug was completely discontinued. Some now only take a few tablets to help them through critical situations...." ***(Kavinoky, N. R.: J. Am. M. Women's A. 7:294, Aug. 1952.)***

"...the combination of drugs present in Bellergal served admirably [in premenstrual tension and disturbances of the menopause] in the reduction of symptoms, both as to degree and number. The improved sense of well-being offers satisfactory evidence that such patients may derive considerable benefit from this simple method of treatment." ***(Craig, P. E.: M. Times 81:485, July 1953.)***



"...of 303 gynecologic patients [premenstrual tension, dysmenorrhea, menstrual irregularity, postmenstrual tension]... a total of 90 per cent of the cases were benefited by the use of this drug." ***(MacFadyen, B. V.: Am. Pract. & Digest. Treat. 2:1028, Dec. 1951.)***

for functional disorders of menstruation and menopause

BELLERGAL®
Spacetabs®

effectively relieve distress of
hot flashes...sweating...
headache...fatigue...irritability...
palpitation...insomnia

BELLERGAL SPACETABS

Bellafoline 0.2 mg., ergotamine tartrate 0.6 mg., phenobarbital 40.0 mg.
Dosage: **1 in the morning, and 1 in the evening.**

BELLERGAL TABLETS

Bellafoline 0.1 mg., ergotamine tartrate 0.3 mg., phenobarbital 20.0 mg.
Dosage: **3 to 4 daily. In more resistant cases, dosage begins with 6 tablets daily and is slowly reduced.**

SANDOZ

How to Pick a Collection Agency

Continued from 69

agency take you on without requiring that you sign a contract?

The better professional collection agencies seldom insist on written contracts. By shunning the dotted line, you'll automatically avoid some hidden traps that have caught many another doctor. Among the seemingly innocent contract provisions that can spell trouble:

¶ An agreement that the doctor will pay a "service charge" or "investigation fee" on every account he turns over. (This means he'll owe the agency money whether or not it collects a cent.)

¶ A "collect in full" provision that promises payment to the doctor only after an account is *fully* paid. (Many never are, of course.)

¶ A clause requiring the doctor to pay the agency's commission on an account before the account will be returned to him for any reason.

¶ A fine-print agreement binding the doctor to accept stock in the agency as payment for collected money.

"I'd guess that more than 80 per cent of the men who've been bilked by unscrupulous collection outfits have been taken in by the promise of low charges combined with tricky contracts," comments one medical society bureau manager. "The safest bet, and the simplest: Steer clear of both."

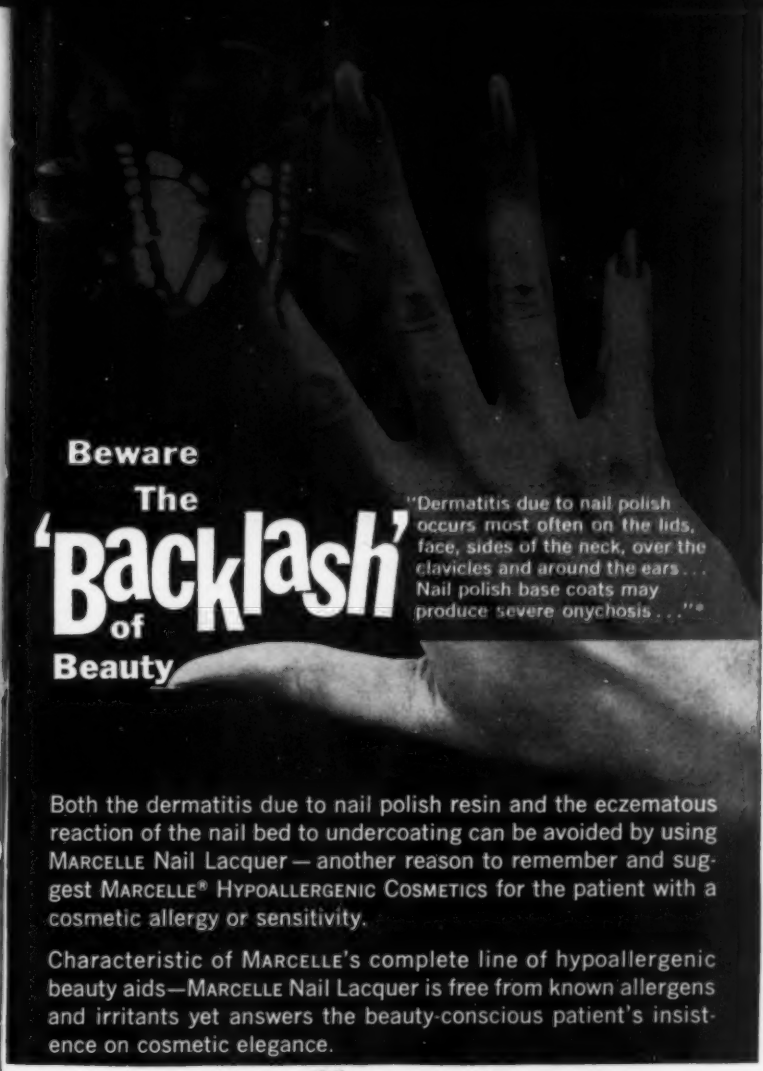
5. Is the agency used and endorsed by other local doctors?

"About a year after setting up practice here, I picked what I thought was a first-rate agency," reports a regretful Los Angeles physician. "It was well established and financially sound, and the manager assured me they'd had plenty of medical collection experience. He was right. But it took me six months to discover what many of my colleagues could have told me: The outfit's 'experience' had been almost wholly with dissatisfied physicians who no longer used it."

Your local medical society can probably give you the names of members who use or *have used* any agency you're considering. You'll do well to ask those men and others what they think of the concern.

Among other checks you might want to make:

You can get a line on an agen-



Both the dermatitis due to nail polish resin and the eczematous reaction of the nail bed to undercoating can be avoided by using MARCELLE Nail Lacquer — another reason to remember and suggest MARCELLE® HYPOALLERGENIC COSMETICS for the patient with a cosmetic allergy or sensitivity.

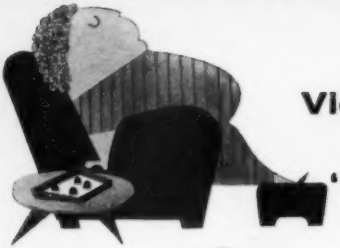
Characteristic of MARCELLE's complete line of hypoallergenic beauty aids—MARCELLE Nail Lacquer is free from known allergens and irritants yet answers the beauty-conscious patient's insistence on cosmetic elegance.

Marcelle COSMETICS

Borden PHARMACEUTICAL DIVISION
350 Madison Avenue, New York 17

Available in Canada through Prof. Sales Corp., Montreal

*Andrews, G. C.: Diseases of the Skin, ed. 4, Philadelphia, Saunders, 1954, pp. 117, 118.



Victim of Overeating and "Oversitting"

℞

BIPHETAMINE®

A 'STRASIONIC' RELEASE ANORETIC — RESIN

- **10-14 Hour Appetite Curb**
- **10-14 Hour Mild Invigoration**
- **Predictable Weight Loss...**
  a comfortable 1 to 3 lbs. a week in 9 out of 10 cases

In many instances both appetite limitation and mild invigoration ('Biphetamine') are required to effect the balance between caloric intake and energy output necessary for predictable weight reduction and control. Since 'Strasionic' release is employed, the desired therapeutic action is uniform, predictable and comfortable.

Biphetamine may be prescribed for obese patients who are hypertensive, arthritic, diabetic, pregnant, menopausal, aged; and to reduce surgical risks. Use with initial care in patients hypersensitive to sympathomimetic compounds, in cases of coronary disease or severe hypertension.

- **Single Capsule Daily Dose 10 to 14 hours before retiring**

3 STRENGTHS

List No. 875
BIPHETAMINE® '20' Resin
Each black capsule contains:
d-amphetamine ..... 10 mg.
dl-amphetamine ..... 10 mg.
as resin complexes

List No. 878
BIPHETAMINE® '12½' Resin
Each black and white capsule contains:
d-amphetamine .....6.25 mg.
dl-amphetamine .....6.25 mg.
as resin complexes

List No. 895
BIPHETAMINE® '7½' Resin
Each white capsule contains:
d-amphetamine .....3.75 mg.
dl-amphetamine .....3.75 mg.
as resin complexes

Rx Only. Caution: Federal law prohibits dispensing without prescription.

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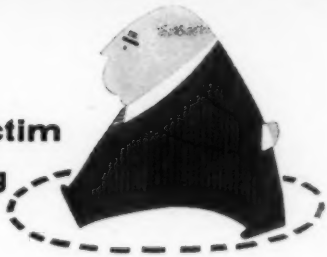
ROCHESTER 1, N.Y., U.S.A.

Originators of 'Strasionic' (sustained ionic) Release



Victim of Overeating

℞ NEW **Non-Amphetamine**

IONAMIN™

A 'STRASIONIC' ANORETIC

PHENYL-*TERT.*-BUTYLAMINE RESIN

- **10-14 Hour Appetite Curb**
- **Predictable Weight Loss...**
  a comfortable .221 lbs. per day in average case

BALANCE

In many instances, appetite limitation only ('Ionamin') is required to effect the balance between caloric intake and energy output necessary for predictable weight reduction and control. Since 'Strasionic' release is employed, the desired therapeutic action is uniform, predictable and comfortable.

Ionamin may be prescribed for obese patients who are arthritic, diabetic, pregnant, menopausal, aged, to reduce surgical risks, and may be used with caution in hypertensive or cardiovascular disease.

- **Single Capsule Daily Dose 10 to 14 hours before retiring**

2 STRENGTHS

℞ Only. **Caution:** Federal law prohibits dispensing without prescription.

List No. 904

IONAMIN™ '30'

Each yellow capsule contains: phenyl-tert.-butylamine . . . 30 mg. as a resin complex

List No. 903

IONAMIN™ '15'

Each gray and yellow capsule contains: phenyl-tert.-butylamine . . . 15 mg. as a resin complex

STRASENBURGH LABORATORIES

ROCHESTER, N.Y., U.S.A.

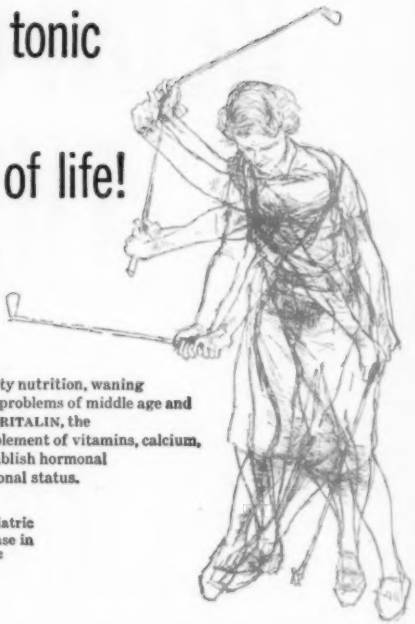
Originators of 'Strasionic' (sustained ionic) Release

cy's financial standing through the Associated Credit Bureaus of America, the American Collectors Association, or the Medical-Dental-Hospital Bureaus. And your local Chamber of Commerce, as well as the Better Business Bureau, can tell you something about the firm's general reputation.

6. Are its procedures of a kind you yourself would approve?

While other doctors can steer you away from a lemon, they can't always help you choose the plum. One physician may swear by an agency that uses hard-

New revitalizing tonic brightens the second half of life!



Ritonic™

A sense of frustration and inadequacy, faulty nutrition, waning gonadal function—RITONIC meets all these problems of middle age and senile let-down. The unique combination of RITALIN, the *safe* central stimulant, with a balanced complement of vitamins, calcium, and hormones acts to renew vitality, re-establish hormonal and anabolic benefits, and improve nutritional status.

"We found Ritonic to be a safe, effective geriatric supplement . . ."[1] "Patients reported an increase in alertness, vitality and sense of well being."[2]

PRESCRIBE RITONIC

for your geriatric patients, your middle-aged patients and your postmenopausal patients.

Each Ritonic Capsule contains:

Ritalin® hydrochloride	5 mg.
methyltestosterone	1.25 mg.
ethinyl estradiol	5 micrograms
thiamin (vitamin B_1)	5 mg.
riboflavin (vitamin B_2)	1 mg.
pyridoxin (vitamin B_6)	2 mg.
vitamin B_{12} activity	2 micrograms
nicotinamide	25 mg.
dicalcium phosphate	250 mg.

Dosage: One Ritonic Capsule in mid-morning and one in mid-afternoon.
Supplied: Ritonic CAPSULES; bottles of 100.
References: 1. Natenshon, A. L.: J. Am. Geriatrics Soc. *6*: 534 (July) 1958.
2. Bachrach, S.: To be published.
RITALIN® hydrochloride (methylphenidate hydrochloride CIBA)

CIBA

REINFORCED THERAPY FOR REFRACTORY INFECTIONS

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

NEW

ILOSONE™ SULFA

(propionyl erythromycin ester with triple sulfas, Lilly)

DECISIVE: A fast, decisive resolution of mixed or refractory bacterial infections is obtained with greater certainty when you prescribe Ilosone Sulfa. This safe and logical combination provides the proved efficacy of triple sulfonamide therapy, reinforced with the striking antibiotic effectiveness of new Ilosone™.

DISTINCTIVE: The distinctive yellow tablet is easy to swallow because of its oblong shape and thin wax coating. The coating also conceals the taste of the medication but does not interfere with its rapid absorption. The tablet is scored to allow full flexibility of dosage.

032001

each scored tablet provides:

Ilosone	125 mg.
Sulfadiazine	167 mg.
Sulfamerazine	167 mg.
Sulfamethazine	167 mg.

usual adult dosage: 2 tablets every six hours.

supplied: in bottles of 24 tablets (three days' therapy).

Ilosone™ (propionyl erythromycin ester, Lilly)

boiled tactics. Another prefers an outfit whose watchword is gentleness. The right collection procedures for you must depend on your own type of practice.

Any reputable agency will be glad to tell you in detail how it plans to handle your accounts. It will show you its standard form letters and samples of individual follow-up letters. It will explain its techniques for handling special cases. And while you're examining the paper procedures, you can also take a look at the men who administer them.

Some good advice from Medical-Dental-Hospital Bureaus' Forrest W. Tucker: "Ask yourself if you'd want the agency's head man on your letterhead. You won't put him there, of course. But if you'd be ashamed to, you don't want him for your bill collector."

7. Will it permit you to make all final decisions on your accounts?

Ethical collection agencies and their doctor-clients have parted bitterly for want of a clear-cut understanding. That's why it seems wise to have an agreement with your chosen agency that it will abide by the following rules:

It will give you a report on any case that seems to deserve special consideration, and it will follow your instructions on handling such cases. It will give you final say in the disposition of accounts, deferring to your decisions as to fee adjustments, write-offs, etc. And it will *never* threaten suit on an account unless you've given prior permission.

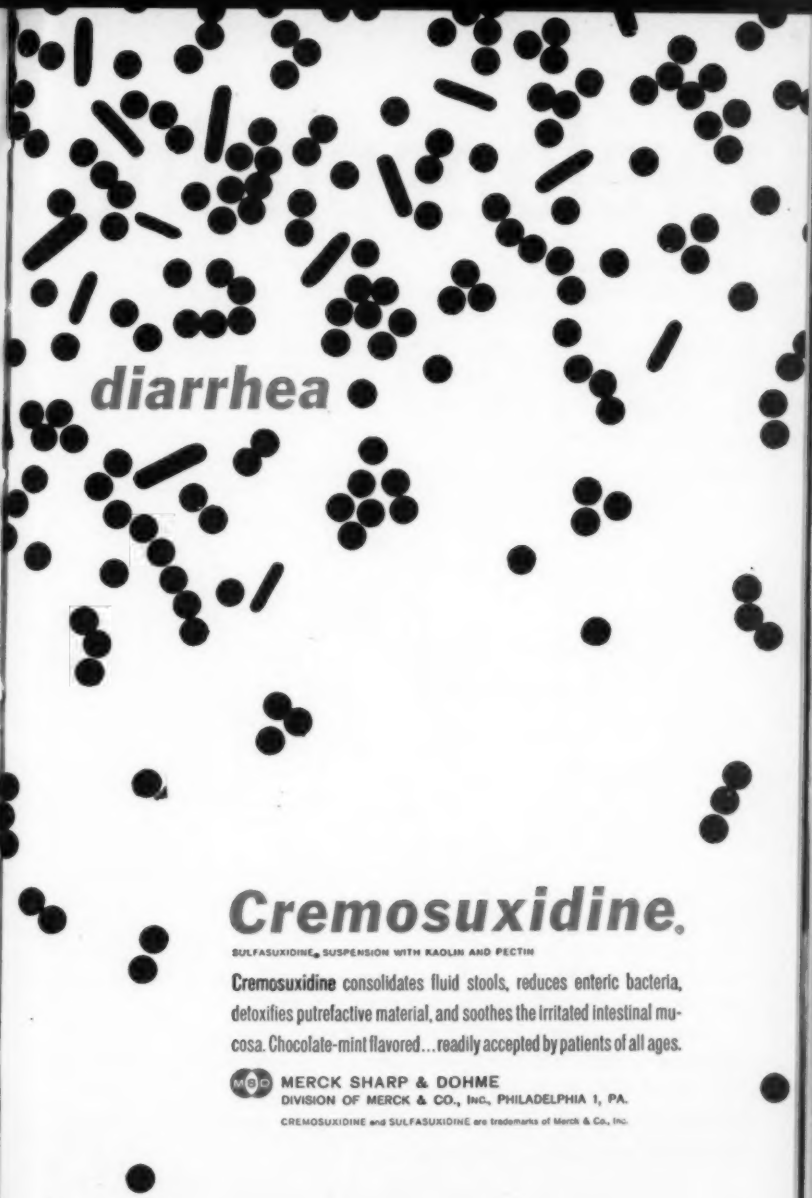
If you pick an agency that meets all seven of the above requirements, you can assume you've picked a good one. But if you want it to work for you at top efficiency, you'll do your best to meet *its* requirements. For a profitable and lasting relationship, you'll cooperate with the organization in four important ways:

A. You'll give it all necessary information about every account you turn over.

B. You'll give it a full explanation of any fees that need clarification.

C. You'll stop billing the patient once you've handed over his account.

D. You'll turn over delinquent accounts after an agreed-on period—six or nine months, say—of unsuccessful billing. END



Cremosuxidine®

SULFASUXIDINE®, SUSPENSION WITH KAOLIN AND PECTIN

Cremosuxidine consolidates fluid stools, reduces enteric bacteria, detoxifies putrefactive material, and soothes the irritated intestinal mucosa. Chocolate-mint flavored... readily accepted by patients of all ages.

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pyelonephritis

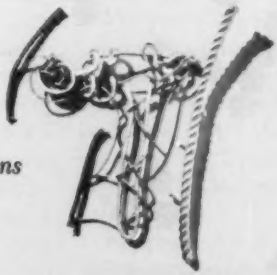
"the most important concept is that it is a tubular disease"[1]

FURADANTIN®

brand of nitrofurantoin

a most important characteristic: effective at the tubular level

in each patient:
2 million reasons
for using
FURADANTIN first



In addition to simple glomerular filtration, FURADANTIN is actively excreted by the cells of the tubules. A significant and singular characteristic of FURADANTIN, it is but one reason why "the protracted administration of nitrofurantoin [FURADANTIN] to patients with ineradicable urinary tract infection, particularly chronic pyelonephritis without demonstrable obstruction, may usefully complement the medical management of this difficult problem."[2]

Available as Tablets, 50 and 100 mg.; Oral Suspension, 25 mg. per 5 cc. tsp.

References: 1. Smith, I. M., and Lenyo, L.: Am. Practitioner 9:78, 1958. 2. Jawetz, E., et al.: A.M.A. Arch. Int. M. 100:549, 1957.

NITROFURANS—a *unique* class of antimicrobials—neither antibiotics nor sulfonamides

EATON LABORATORIES, NORWICH, NEW YORK

How the Keogh Bill Could Change Your Life

Continued from 81

"Long overdue" and "badly needed" are typical comments. "I wish a plan like that had been devised when I was young enough to participate," says one 75-year-old doctor. "As it is, I have no pension fund, no retirement savings, and no Social Security. And I feel the lack keenly."

"In my case," adds another man, "the Keogh bill would make all the difference in the world between worry over the future and peace of mind. Last year, my net was up $13,000, but my taxes were up $11,000. Under the present tax law, does it really pay to work harder?"

Though Social Security wasn't even mentioned on the questionnaire, many of the surveyed men stated that they favor extending the program to doctors.

"Physicians shouldn't be so

"The raise? I didn't get it. He said someone might figure it was fee splitting!"

snooty about being covered by Social Security," says one such respondent. "If they haven't got enough brains to come in out of the rain, the Government should make them."

Some doctors apparently believe that Social Security is more important than the Keogh bill. Explains one medical man: "I'm against the Keogh bill until I become convinced that it will not be used by the A.M.A. to oppose inclusion of doctors under Social Security. Once doctors are brought under Social Security, I will support the Keogh bill."

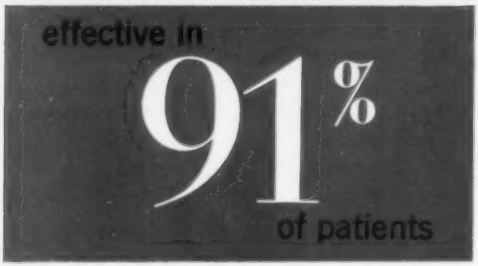
More than 96 per cent of the responding doctors say they'll take advantage of the Keogh bill if it becomes law.

Nearly half the respondents indicate a willingness and ability to set aside as much as $2,500 a year in a tax-deferred retirement fund. (That's the maximum allowed for most people under the Keogh bill as it now stands.) The other doctors would save varying amounts ranging down to $500 a year. Of the 2,635 physician-respondents, only 124 say they wouldn't take advantage of the new law.

The Keogh bill provides for two different ways of accumulating tax-deferred funds: They could be invested in a "restricted

1½ minutes of your time reading about Trancopal may change your prescription habits when treating musculoskeletal and psychogenic disorders.

in musculoskeletal conditions[1]



Low back pain (lumbago)
Bursitis
Osteoarthritis
Fibrositis
Myositis
Postoperative myalgias

Neck pain (torticollis)
Rheumatoid arthritis
Disk syndrome
Joint disorders (ankle sprain, tennis elbow, etc.)

By relieving muscle spasm and pain, Trancopal permits early and active purposeful exercise and physical therapy to accomplish maximal benefits for rapid recovery.

thoroughly evaluated clinically

Clinical studies of 4092 patients by 105 physicians[1] have demonstrated that Trancopal often is effective when other drugs have failed. From these studies it is evident that Trancopal can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than can any other chemotherapeutic agent in current use.

Trancopal®

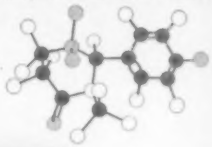
the first true tranquilaxant*

***Potent* MUSCLE RELAXANT**

***...Equally effective as a* TRANQUILIZER**

Chlormezanone: 2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

Unrelated chemically to any other drug in current use, Trancopal offers a completely new major chemical contribution to therapeutics.



in anxiety and tension states[1]

effective in

88%

of patients

Anxiety and tension states	Dysmenorrhea
Premenstrual tension	Asthma
Emphysema	Angina pectoris

Because of its exceptional calmative property, Trancopal "... allows the patient to use his energies in a more productive manner in overcoming his basic problem."[2]

better tolerated and safer than older drugs[3]

With Trancopal there is no clouding of consciousness, no euphoria or depression. Even in high dosage, there is no perceptible soporific effect. Because it does not irritate gastric mucosa, it can be taken without regard to mealtimes. Administration does not hamper work – or play. There are no known contraindications.

Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage. Toxicity is extremely low. And Trancopal has a lower incidence of side effects than has zoxazolamine, methocarbamol or meprobamate.

Dosage: One Caplet (100 mg.) orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

References: 1. Cooperative Study, Department of Medical Research, Winthrop Laboratories. 2. Gans, S.E.: To be published. 3. Lichtman, A.L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.

tran'kwi-lak'sant [<L. *tranquillus*, quiet; *laxare*, to loosen, as the muscles]

Winthrop LABORATORIES
New York 18, New York

Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U.S. Pat. Off.

1350M

retirement fund" held in trust by a bank; or they could be put into a "restricted retirement policy" issued by a life insurance company. Some 65 per cent of the respondents express preference for a bank-trusteed fund. Another 11 per cent vote for an insurance company annuity. The rest have no firm opinion as yet.

Would the typical doctor want to set up his own plan? Or would he prefer to accept an arrangement set up by his medical society? "It depends on which seems to offer the better deal," says one M.D. This wait-and-see attitude is shared by a great many of the surveyed doctors.

As to how they'd want their retirement funds invested, the doctors seem distinctly conservative. Only about 8 per cent wouldn't invest *any* of the money in common stocks; only about 8 per cent would invest *entirely* in common stocks. The others would want their investments diversified: common stocks for growth and protection against inflation; fixed-income securities for stability; and Government bonds for maximum safety.

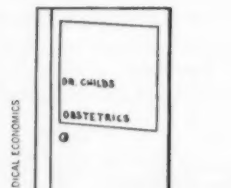
What does the survey add up to?

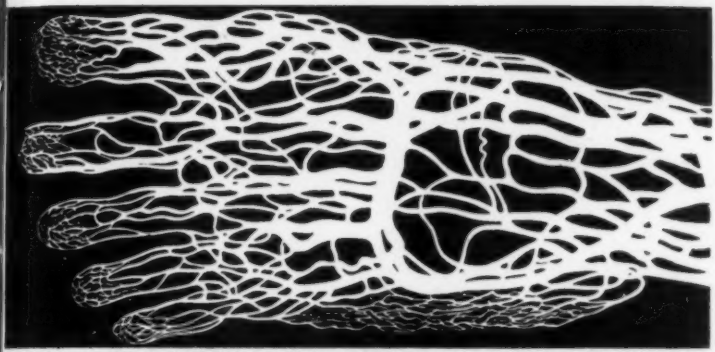
A Banker's View of It

"The picture we draw shows an even greater need for the Keogh bill than we anticipated," says Charles M. Bliss, executive vice president of The Bank of New York. "It shows that under the present tax structure, the self-employed are generally unable to save for their retirement years. And it also shows that they could and would if the Keogh bill were to become law."

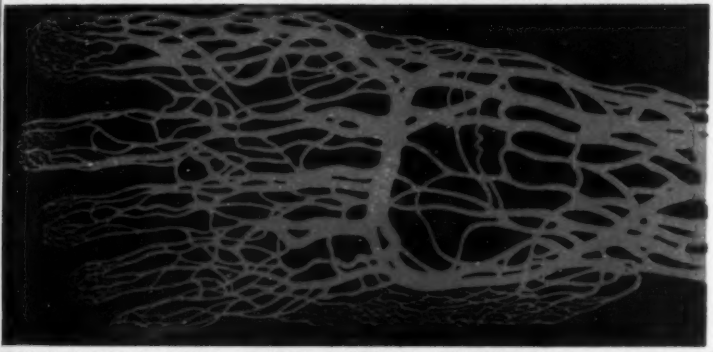
What can you do to help break the eight-year pattern of frustration? Charles Bliss' answer:

"Doctors should start now to study the Keogh bill, to understand what it means, to tell their colleagues and elected representatives why they favor it. For thousands of physicians, enactment of the measure might be the key—the only key—to a happy and secure retirement." END





WHEN YOUR PATIENT NEEDS BETTER PERIPHERAL CIRCULATION



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Memo

From the Editors

Coming in June

"Most doctors don't *buy* their insurance. It's *sold* to them. As a result, they seldom get the greatest value for their money."

MEDICAL ECONOMICS made this observation years ago. Ever since, it's aimed to help doctors become better-informed buyers of insurance. Today such help is more in demand than ever—and no wonder:

Today's typical doctor will pay between $50,000 and $75,000 for insurance protection during his lifetime. Yet he won't get the greatest value for all that money unless he also pays attention to new offerings and new complications as they arise.

New offerings? See "Now You Can Insure Your Insurability," page 131, this issue. New complications? See "The Facts About Lloyd's Malpractice Insurance," page 70. These current articles show how MEDICAL ECONOMICS helps.

More help is just ahead. If you really want to get the most for your life insurance dollars, don't miss these forthcoming articles:

¶ "How to Add Value to Your Life Insurance." Heard about riders? Double indemnity is the best-known one. But at least half a dozen newer or more valuable riders can be added to a life insurance policy you now own. Here's a buyer's guide comparing costs and benefits. Among the riders evaluated for you are those providing family income, disability income, return of premium, and return of cash value.

¶ "Family Plan Life Insurance: Is It for You?" This new type of policy covers your wife and children at little extra cost. Under certain circumstances, it can be a real bargain. Read all about it next month.

¶ "Individual Life Insurance at Group Rates." Now doctors can get policies of their own at lower prices than ever. This article tells how medical society members in Chicago and New York have shown the way.

Like all such articles in MEDICAL ECONOMICS, these stem from the best independent sources we can find. They're fact-checked by trade sources (e.g., the Institute of Life Insurance) before they're printed. But it's their independent opinions—biased in favor of the buyer—that make them money-savers for you. END